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Harm Reduction with People Who Use Psychoactive Substances:  
Social Workers' Perceptions of Harm Reduction Work and in Implementing Harm  
Reduction Work in their Direct Clinical Practice in Rural Central Ontario

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### Abstract

Harm reduction approaches to psychoactive substance use continue to be a highly politicized and polarizing topic in today's society, even after several decades of ongoing discourse. Many social workers work for and with organizations that include harm reduction approaches to social work direct practice with individuals who use psychoactive substances. This qualitative study of six participants explores social workers' perceptions of harm reduction work with individuals who use psychoactive substances and the ways in which they perceive the implementation and operationalization of harm reduction approaches in their direct practice in rural Central Ontario. A semi-structured interview design was used, with the research grounded in structural social work theory, as well as critical ecological theory and a person-centered perspective. Findings indicate that stigma of individuals who use psychoactive substances and associated harm reduction work is deeply rooted and reinforced within structural systems, organizations, and within social work and harm reduction work, itself. Social workers' perception of harm reduction and its implementation cite organizational culture, social work as harm reduction work, and clinical barriers to implementation as main themes in the social work direct practice role, working with individuals who use psychoactive substances. Social workers are equipped to support harm reduction work through their social work worldview, and benefit from an organizational culture that both formally and informally supports harm reduction work. An aligned organizational culture and social work worldview can more effectively advocate for greater availability and accessibility of harm reduction programming and services. Implications for research, policy, and practice are discussed.

*Keywords:* harm reduction, organizational culture, psychoactive substance use, rural, social work, stigma

### Résumé

Les approches de réduction des méfaits de l'utilisation des substances psychoactives continue d'être un sujet hautement politisé et polarisant dans la société d'aujourd'hui, même après plusieurs décennies de discours. Beaucoup de travailleurs sociaux travaillent pour et avec des organisations qui incluent des approches de réduction des méfaits dans la pratique directe du travail social avec des personnes qui utilisent des substances psychoactives. Cette étude qualitative de six participants explore les perceptions des travailleurs sociaux sur le travail de réduction des méfaits avec les personnes qui utilisent des substances psychoactives et la façon dont ils perçoivent la mise en œuvre et l'opérationnalisation des approches de réduction des méfaits dans leur pratique directe dans les régions rurales du centre de l'Ontario. Un modèle d'entrevue semi-structurée a été utilisé, la recherche étant basée sur la théorie du travail social structurel, ainsi que sur la théorie écologique critique et une perspective axée sur la personne. Les résultats indiquent que la stigmatisation des personnes qui utilisent des substances psychoactives et le travail de réduction des méfaits qui y est associé sont profondément enracinée et renforcée dans les systèmes structurels, des organisations, et du travail social et le travail de réduction des méfaits lui-même. La perception des travailleurs sociaux de la réduction des méfaits et de sa mise en œuvre cite la culture organisationnelle, le travail social en tant que travail de réduction des méfaits et les obstacles cliniques à la mise en œuvre comme thèmes principaux du rôle de la pratique directe du travail social, en travaillant avec des personnes qui utilisent des substances psychoactives. Les travailleurs sociaux sont équipés pour soutenir le travail de réduction des méfaits par leurs vision du monde du travail social et bénéficient d'une culture organisationnelle qui soutient formellement et informellement le travail de réduction des méfaits. Une culture organisationnelle alignée avec une vision due monde du travail social peuvent plaider plus efficacement en faveur d'une plus grande disponibilité et accessibilité des programmes et des services de réduction des méfaits. Les implications pour la recherche, les politiques et la pratique sont discutées

*Mots-clés:* réduction des méfaits, culture organisationnelle, consommation de substances psychoactives, rural, travail social, stigmatisation

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I wish to acknowledge that Huntsville, Ontario, where I have completed my MSW Thesis, is located on the traditional land of the Anishinaabe people. The colonialization of Indigenous groups in Canada is not historical, but rather, ongoing. As a social worker I am part of a long history of supporting colonialization and I wish to acknowledge the role of social work in this history and ongoing colonialization. I use this space to acknowledge my privilege as a white woman with the means to acquire an academic education. My aim is to use my structural privilege to work with people who experience structural oppression, while reflecting on how my whiteness is embedded in my work and working to minimize and challenge the impact of that embedment.

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### **Introduction**

Social work, as a profession, supports individuals' right to self-determination, approaching the person through a lens that understands oppression stemming from larger structural systems and its impacts on an individual's access to economic, political, and social wellbeing (Lundy, 2011). Social work can support a critical lens of these impacting, oppressive systems. Social workers' employed in a number of roles and working with different populations will find themselves working with individuals who use psychoactive substances.

Individuals use a variety of psychoactive substances, both licit and illicit. The social acceptance of psychoactive substances can change with culture and over time (Csiernik & Rowe, 2017). A study from 2012 found that approximately 1.4 million, or approximately 4% of Canadians met the criteria for a substance use disorder (Statistics Canada, 2013). The onset of licit and illicit opioid use in Canada saw 2458 deaths due to apparent opioid-related overdoses in 2016, a statistic greater than the number of deaths by motor vehicle accident (Government of Canada, 2017).

It is important that social workers' feel knowledgeable and skilled in supporting individuals who use psychoactive substances through approaches, frameworks, and interventions that support this demographic and the communities to which they are linked. Social workers who are knowledgeable and skilled in harm reduction approaches to psychoactive substance use support evidence-informed practice and challenge the stigmatization of psychoactive substance use and progress harm reduction strategies an individual and community level.

Harm reduction is a critical framework for supporting individuals who use psychoactive substances that focuses on the health, social, economic, and political risks associated with a person's substance use, rather than the use itself (BCCDC, 2018). Harm reduction work, as an approach to policy, programs, and direct practice, situates itself well with social work as a non-judgemental, person-centered, trauma-informed approach that respects a person's right to make their own decisions about their health and their life, and advocate to support social justice and dismantle stigma for individual's who use substances. Harm reduction is compatible with social work and reflective of social work values such as a person-centered approach and an individual's right to self-determination and social justice (Csiernik & Rowe, 2017).

Social workers in roles that support individuals using psychoactive substances require knowledge of harm reduction work and how to effectively implement harm reduction in their direct practice. In working with the variety of intersecting populations that social worker's serve, knowledge of harm reduction acts not only an evidence-informed approach to social work, but as a means of practice that reflects social work ethics, knowledge, skills, values, and education.

This study explores social workers' perception of harm reduction work and the implementation of harm reduction work in their direct social work practice in rural Central Ontario.

### **Conceptualization of Addiction**

#### **Defining 'Addiction'**

Addiction is a term used to describe problematic psychoactive substance use (CAMH, 2019). Addiction, as terminology for psychoactive substance use, is vague and

often overused, and used incorrectly in our society (Csiernik, 2016). The vague nature of the term is problematic in that it labels a person based on a specific behaviour and supports that behaviour as becoming a person's main attribute (Csiernik & Rowe, 2017). Definitions of addiction have, over the years, focused on a loss of control, an avoidance of withdrawal, a chronic disease, and a social experience, among others (Csiernik, 2016). Addiction can best be viewed through a holistic lens that understands addiction as a bio-psycho-social phenomenon (Csiernik, 2016).

### **Theories of Addiction**

Theories of addiction are a highly argued and contentious issue amongst scholars, treatment providers, politicians, and public society at large. Theories of addiction fall into four main perspectives: moral, biological, psychological, and sociological (Csiernik, 2016).

#### **The Moral Model**

The moral model of substance use understands that any use of substance is wrong and sinful, and founded out of religious beliefs about individual values, the moral model understands addicts as inherently bad people who do bad things, who must be treated through punitive measures (Csiernik, 2016). America's ongoing 'War on Drugs' exemplifies the moral, punitive approach to substance use, and the belief that people who use drugs are 'bad people' who need to be punished rather than treated (Csiernik, 2016). At an International level, punitive approaches to psychoactive substance are exemplified through use of the the death penalty for often even minor drug offences, with over 4,000 people being executed for drug offences between 2008 and 2018 (Girelli, 2019).

The moral model does not separate the person from the behaviour, rather the behaviour is a product or symptom of the persons deficiencies. In a 'free' and liberal society, freewill and individual autonomy are highly valued ideals (Mullaly, 2007). The moral model is consistent with these values, understanding that an individual's success is equated to their motivation or drive. People have the means for success if they work hard enough. These social ideals of hard work equating to success support the stigmatization of individuals who use psychoactive substances and continue to reinforce moral deficit as the cause of substance use and addiction.

### **Biological Models**

Biological models of addiction include the disease or medical model that understands addiction as a chronic and lifelong illness that results in a loss of control over using (Wiens & Walker, 2015). The disease model seeks to remove moral failings or lack of will as being the factors contributing to an individuals addiction, and allows the 'addict' to be accountable to their behaviours and yet disown acts committed while actively using. The using individual becomes "simultaneously responsible and not responsible" (Hammer, Dingel, Ostergren, Partridge, McCormick, & Koenig, 2013, p. 3) for their behaviour. The pathological, disease model of addiction displaced the concept of addiction as a moral failing, mitigating the stigma associated with becoming an addict (Wiens & Walker, 2015). Satel & Lilienfeld (2014) suggest that proponents of the disease model sought to medicalize substance use as a powerful way "to rehabilitate addicts' poor public image from the perception of undisciplined deadbeats to people struggling with an ailment" (p. 4). This transition to of substance use and addiction as disease had been previously utilized by mental health advocates who had utilized neuroscience as a

means to de-stigmatize mental illnesses such as schizophrenia by demonstrating that they were a product of abnormal brain structure and function and not parental failings (Satel & Lilienfeld, 2014).

Despite the entrenched position amongst many national research institutes, health care officials, public health policy makers, addiction treatment professionals, and other proponents of the medical model of addiction (Satel & Lilienfeld, 2014), a large amount of empirical evidence challenges substance use as pathological (Levy, 2013; Weins & Walker, 2015; Hammer et al., 2013; Satel & Lilienfeld, 2014). Levy (2013) argues that while addiction does result in neurological dysfunction, this impairment cannot be generalized as disease. Instead, impairment must be “understood relative to the social and practical context in which addicts live” (Pickard, Ahmed, & Foddy, 2015, p.1). In the same line of thought, Satel & Lilienfeld (2014) insist, “although severe addictions are partly rooted in genetic predispositions that are themselves manifested in brain functioning, these conditions can be profitably understood at multiple levels of analysis (e.g., psychological, social, cultural) in addition to the neural level” (p. 2).

### **Psychological & Sociological Models**

Psychological and sociological models of addiction understand that substance use and addiction is not solely a product of biological causes but rather a dynamic relationship that involves factors that are external to the individual (Csiernik, 2016). Psychological and sociological models of addiction focus on an individual's substance use behaviours as being secondary to other psychological problems or conditions (Fisher & Harrison, 2000).

Psychological models of addiction include learning theory, personality theory, psychodynamic theory, humanistic theory, attachment theory, and rational theory (Csiernik, 2016). While sociological models include cultural theories, subcultural theories, deviant behaviour theory, Marxist theory, availability-control theory, and environment stress (Csiernik, 2016).

A popular theory is that of the impact of childhood trauma on psychoactive substance use behaviours. Gabor Maté popularized this connection between childhood trauma and addiction, suggesting, “all addictions – alcohol or drugs, sex addiction or internet addiction, gambling, or shopping, are attempts to regulate our internal emotional states because we are not comfortable, and the discomfort originates in childhood” (Waters, 2019, para. 8). While some argue Maté’s theory is somewhat reductionist, it supports ongoing discussion on the causes of psychoactive substance use and challenges a social paradigm that often continues to place blame on the individual.

Psychological and sociological models of addiction serve to broaden the conversation of addiction to include outside forces, that perhaps our bodies and our external environments and experiences are not mutually exclusive.

### **The Bio-psycho-social Model**

While there may be a genetic or biological predisposition towards substance use that becomes problematic, psychoactive substance use can best be recognized and understood through a broader lens that incorporates biological, psychological, sociological, cultural, and other environmental factors in order to contextualize psychoactive substance use as relevant and relative to the individual experiencing it.

The bio-psycho-social model of addiction explores the interactions of an individual's biology, psychology, cognition, social, developmental, cultural, and environmental variables in order to best "explain" addiction (Fisher & Harrison, 2000).

A broader, more eclectic approach to examining addiction, the bio-psycho-social model understands that psychoactive substance use does not come with a simple explanation, rather, psychoactive substance use and its impacts are relative to the person experiencing, it the context of the variables impacting their life.

The bio-psycho-social model of psychoactive substance use aligns usefully with the social work worldview.

### **Absence of the Term 'Addiction'**

This research aims at de-stigmatizing psychoactive substance use by omitting the term 'addiction' or 'addict' from the research. The concept of psychoactive substance use rather than addiction more effectively fits the harm reduction philosophy of a person-centered approach that understands labelling and stigmatization as an oppressive action. Given the ambiguity of the term addiction and the corresponding labels that the term supports, it seemed necessary to omit it and utilize more objective terminology. The aim was to focus on harm reduction, not only as a tool for 'addiction', whatever the definition, rather as a tool for all psychoactive substance use. One does not have to be 'addicted' in order to utilize and/or benefit from harm reduction philosophy, practices, and approaches. Harm reduction is an inclusive approach that can be used by any individual who uses psychoactive substances to minimize harms, unlike treatment approaches that require an individual to have "hit rock bottom". Therefore, the term, "psychoactive substance use" and "individual who uses psychoactive substances" is used throughout the study to

minimize stigma and support broader conversation and implementation of harm reduction approaches outside of 'addiction'.

## **Literature Review**

### **Psychoactive Substance Use and Stigma**

Individuals who use psychoactive substances, and particularly those who use illicit substances, use licit substances illicitly, or have experienced problematic behaviours associated with their substance use, are often stereotyped and stigmatized in an increasingly individualistic society that blames the "addict" for their behaviour and lack of ability to restrain. Ongoing approaches to Canada's drug policy are shaped by these stereotypes, and perpetuate the stigmatization of individuals who use psychoactive substances (Csiernik & Rowe, 2017). The response to substance use has consistently been to criminalize the individual who uses psychoactive substances, using largely punitive measures that act as short-term behavioural 'solutions', such as criminal charges and jail sentences, rather than developing or increasing the provision of support services that might allow individuals to change their lives (Kellen, Powers & Birnbaum, 2017). The 'War on Drugs' has effectively been a war on people, with the "addict" or "substance user", as the "Other", and further marginalizing an already oppressed population of people. The blaming of the individual who uses psychoactive substances is embedded in our society, viewing substance use as a moral deficiency and constitutes a form of systemic violence, by continually re-victimizing the individual who uses psychoactive substances by criminalizing their symptoms and labeling them (Csiernik & Rowe, 2017).

Oppression of the individual who uses psychoactive substances at a systems level takes place as the progressing capitalist agenda, in the form of free trade agreements and



globalization, increases economic and social inequalities (Lundy, 2011). In 2008, the World Health Organization published a report on the social determinants of health that included access to health services, income and income distribution, education, employment and working conditions, early life, gender, and housing among social aspects that determine an individual's health and wellbeing (Lundy, 2011). Mikkonen & Raphael (2010), contextualized the determinants for Canada, and concluded, "the primary factors that shape the health of Canadians are not the medical treatments or lifestyle choices but rather the living conditions they experience" (p.7).

Stigma associated with individuals who use psychoactive substances, represented by negative social attitudes towards individuals who use psychoactive substances, is pervasive and intersectional, in that the stigma is collective of a combination of factors that make an individual vulnerable. Intersectional stigma refers to the meeting of multiple stigmatizing identities, which may include race, gender, sexual orientation, class, and ability, among other identity factors (Turan et al., 2019). Individuals who use psychoactive substances are at heightened risk of stigmatization dependent on race, gender, class, sexual orientation and sexual expression among other identity factors.

Stigma of individuals who use psychoactive substances is further amplified by the persistence of the belief that substance use is deficit behaviour and the insistence that harm reduction work reinforces substance use behaviour (Souleymanov & Allman, 2016).

### **Disseminating Harm Reduction**

Harm reduction as a framework "places first priority on reducing the negative consequences of drug use rather than eliminating drug use or ensuring abstinence" (Riley et al., 1999, p.10) and refers to policies, programs, and practices that attempt to

acknowledge the health, social, economic, and political risks associated with substance use in order to support the minimization of potential harms (Canadian Drug Policy Coalition, 2019).

The impetus behind harm reduction initiatives stemmed from the HIV/AIDs epidemic of the 1980s, and the risks associated with injection drug users sharing injection supplies (Cavalieri & Riley, 2012). At that time harm reduction was a highly contested, highly politicized, grassroots initiative, that saw activists, including healthcare professionals, walking the streets handing out clean needles and injection supplies (Smith, 2012). Harm reduction has a long history of practice in Canada (Cavalieri & Riley, 2012). The first harm reduction interventions in Canada saw grassroots groups handing out clean needles as part of the first needle exchange programs (NEPs) beginning around 1988 in Toronto (Cavalieri & Riley, 2012). After the alarming spread of HIV/AIDS amongst injection drug users, coupled with the acknowledgment that risk of HIV infection was less about the use of illicit drugs itself, and more about the way the route of administration of the drug, the City of Toronto officially took over the initiative in 1989 (Cavalieri & Riley, 2012).

Harm reduction approaches to problematic substance use, within a broad, Canadian societal perception, have been largely conceptualized through a number of specific and familiar public health initiatives; mainly, methadone maintenance and methadone treatment, needle exchange programs, supervised consumption sites, and heroin prescriptions for opioid drug users (Csiernik, Rowe, & Watkin, 2017). In a wide-reaching context, harm reduction has been framed as a public health response to the risks associated with using substances.

Harm reduction can be applied to a number of different impacting aspects of a person's life, such as housing, mental health, and substance use. Buccieri (2010) argues that the ambiguity of the term is directly related to the polarizing ideologies towards abstinence and harm reduction, and because harm reduction functions as philosophy, policy, and practice. Abstinence, the guiding principle behind 12-step, self-help groups such as Alcoholics Anonymous (A.A.), that were the foundation of addiction treatment in North America when helping professionals were at best peripheral in the field, is often understood as the complete cessation of the use of a substance or substances by use of acceptance, powerlessness, and personal restraint. Abstinence-based programs specify that an individual is not "clean" "sober", "or in recovery", until they are completely abstinent from their substance of choice and other illicit substances. While self-help groups such as Alcoholics Anonymous and Narcotics Anonymous allow people to claim their 24-hour sobriety chip as many times as it is earned, and consider relapse as a necessary part of the recovery process, it is difficult to dismiss the self-help group's linear approach towards problematic psychoactive substance use; you use until you are ready to not use. Abstinence as ideology helps to legitimize anti-drug movements by emphasizing the need to cease substances rather than promote more informed use (Roe, 2005).

### **Harm Reduction: Policy, Program, and Practice**

The implementation of harm reduction interventions in Canada has been met with the deeply entrenched and persistent resistance of tough on crime and prohibitionist legislation channelled through the 'free' and liberal society concepts of freewill and individual autonomy. Canadian drug law, in the form of the *Controlled Drugs and*

*Substance Act 1996* (CDSA), is “sounding prohibitionist; and rather than retreating from the drug war rhetoric of the past it expands the net of prohibition further still” (Cavilieri & Riley, 2012, p.2). Within a capitalist society, economic gain eclipses the need to address social inequalities, situated the politicized form of harm reduction in opposition to the moral model of addiction. Instead, harm reduction interventions are framed within a positivist approach that understands interventions from an individualized, medical standpoint, rather than a collectivist, systemic one. Harm reduction as practice is centered on health outcomes that validate the harm reduction rhetoric without pushing the envelope. The utilization of the medical model allows harm reduction to exist as a Band-Aid solution.

The British Columbia Centre for Disease Control (BCCDC) offers five guiding principles towards harm reduction policy, programs, and practices: pragmatism, human rights, a focus on harms, maximization of intervention options, prioritization of immediate goals, and drug user involvement (2011). Pragmatism relates to the reality that people use substances and that the reality of a person's drug use is an individual one. While there are inherent risks for the drug user in using drugs, there are also benefits to the user that must be considered (BCCDC, 2011). Human rights respect a person's basic human dignity and rights, as well as their right to self-determination, and accept, without judgement, a person's decision to use psychoactive substances. A focus on harms places the priority on minimizing harm associated with psychoactive substance use and does not place emphasis on decreasing the use itself. Maximization of intervention options recognizes that individuals who use psychoactive substances benefit from a variety of different support approaches and understand that these approaches must include the

community within which the individual resides. Prioritization of immediate goals focuses on a person's most pressing needs and establishes a hierarchy of achievable goals involving both the person and their community. Finally, drug user involvement understands that the people who use psychoactive substances are in the best position to provide information about psychoactive substance use and interventions. Drug user involvement sees "active participation of drug users as at the heart of harm reduction" (BCCDC, 2011, p. 6).

### **Social Work and Harm Reduction**

Social work has long operated from an ecological systems approach that understands that the person and their environment are "unceasingly, intricately, thoroughly (and more or less successfully) reciprocally sustaining and shaping one another" (Rothery, 2008, p. 91). Mary Richmond, identified as one of the earliest social work pioneers, recognized the role of the environment on peoples' ability to function effectively in society (Pardeck, 2015). Critical ecological systems theory suggests that the main explanation for human problems stems from the complex relationship between psychological, social, economic, political and physical forces (Pardeck, 2015). "The ecological approach addresses solutions and prevention of problems at all levels of intervention - intrapersonal, familial, interpersonal, organizational, institutional, and societal" (Pardeck, 2015, p. 139).

As a means of following the guiding principles of social work, particularly the rights of self-determination and client-centered approaches to practice, social workers need to avoid reproducing pathological, deficit-based ideologies utilized by the medical model, and replace problem-saturated discourse with strengths-based approaches

(Casstevens, 2010). Bok & Morales (1999) insist that when social workers are trained in harm reduction, they often feel that harm reduction reinforces what they already know and do in their practice, mainly, to meet the client where they are at, maintain a non-judgmental attitude, and allow the client set their own goals for change. Many social workers engage in harm reduction methods in their practice without realizing they are doing so, while others think they are utilizing a harm reduction approach when they are not (Bok & Morales, 1999).

Social workers are often employed in agencies that implement harm reduction strategies, yet they do not have a set of principles to guide their practice (Anbar, Buckland, Hope, Layland, & Peckham, 2012). At this time, both the OCSWSSW and the Canadian Association of Social Workers (CASW) fail to provide harm reduction policies, organizational guiding principles, and research to support the use of harm reduction approaches in social work direct practice (Anbar et al., 2012). A policy brief developed by the Canadian Harm Reduction Network in conjunction with the University of Toronto, emphasizes the need for the OCSWSSW to develop a policy statement and associated ethical framework to support the implementation of harm reduction models into social work practice (Anbar et al., 2012). “The context of harm reduction service provision in Ontario necessitates the establishment of guiding social work principles for harm reduction practice by the OCSWSSW to support social workers in the field” (Anbar et al., 2012, p. iii). Education and training on how to implement harm reduction into direct practice with individuals who use substances is necessary in order for social workers to “readily adopt harm reduction principles and strategic interventions while embracing the

pragmatism and client engagement offered by harm reduction opportunities (Anbar, 2012, p. 22).

Vakharia & Little (2017) address this gap in the literature, by acknowledging the alignment of social work and harm reduction work as “natural partners” (p. 66), and providing a set of harm reduction guidelines for social workers to use in their direct clinical practice. Vakharia and Little (2017) identify the basic tenets of harm reduction work and addresses how these tenets can be incorporated into direct social work practice through the therapeutic alliance, the therapeutic treatment environment, a comprehensive client-centered assessment, the establishment of a hierarchy of needs, and the use of various treatment approaches and outcomes of harm reduction as a therapy. Vakharia & Little (2017) indicate that social work must “return to its roots” (p. 75), by challenging current substance use treatment modalities that serve an abstinence based agenda, rather than support that places emphasis on client-centered, strengths-based, and trauma-informed approaches to programming and service.

At a social work education level, substance use, addiction, and harm reduction are not standard course material for undergraduate or graduate social work programs (Graves, Csiernik, Foy, & Cesar, 2009). A study examining the addiction curriculum of undergraduate and graduate social work programs in Canada found that all social work addiction courses were offered in the form of electives and that one third of undergraduate programs do not offer any type of addiction specific course, either core or elective (Graves, et al, 2009). Harm reduction education is largely absent in social work courses at both undergraduate and graduate levels (Eversman, 2012; Fillmore & Hohman, 2015). Bigler demands that social work programs must incorporate harm reduction

models for direct practice into social work education as the traditional abstinence-based models of practice that continue to be part of the substance use curriculum are “often impractical, inefficient, and ineffective” (2005, p. 80.) Social work students often do not consider that they will be working with individuals who use substances, yet substance use permeates all social work fields, including child welfare, geriatric social work, criminal justice work, working with families, and mental health. Fillmore & Hohman (2015) insist that the harm reduction curriculum must be strengthened in order to provide effective methods to students in working with individuals who use substances. Eversman (2012) found the faculty perspectives of harm reduction, much like their students, often varied from acceptance, to indifference, to opposition, and the views were often associated with personal experience with substance use or being in recovery.

Social work and harm reduction work are mutual beneficial when it comes to supporting individuals through client-centered approaches that meet the client where they are at, and respect the individual's rights to self-determination. Both social work and harm reduction work come from social justice beginnings that have devolved into both social work and harm reduction becoming less about social justice and more about maintaining their interventions within existing oppressive systems (Vakharia & Little, 2017).

### **Harm Reduction Implementation and Organizational Culture**

Glisson (2007) asserts that while organizations frequently adopt specific evidence-based practices, they often do not have the knowledge or tools to implement the practices effectively, highlighting a need for practice principles to guide implementation. Evidence-based practice does not always translate at an organizational level. Harm



reduction, it can be argued, is an evidence-informed practice, rather than an evidence-based practice, offering a more inclusive and integrative approach to practice as a client-centered approach to rather than an evidence-centered, as in evidence-based practice (Nevo & Slonim-Nevo, 2011).

A Canadian study by Hobden and Cunningham (2006) found that service providers in Ontario cited anticipation of negative community reactions as well as lack of staff, funding, or anticipated staff resistance as barriers to introducing harm reduction strategies in their practice. While the practice may be evidence-informed, that itself is not enough to merit its adoption by an agency. Minimal literature exists on service provider perspectives of harm reduction and how service providers currently implement harm reduction in their practice (Bigler, 2005; BCCDC, 2011; Karoll, 2010). Harm reduction, while becoming largely accepted as a philosophical underpinning in the public health response to substance use (Poulin, 2006), is a relatively new approach at an agency level (Mancini & Linhorst, 2010). Abstinence-based programming and treatment, often based within segregated inpatient facilities, such as Homewood Health and Stonehenge in Central Ontario, continue to dominate the psychoactive substance use treatment field, serving to reinforce the perceived dichotomy between abstinence-based and harm reduction approaches to psychoactive substance use. The abstinence-based philosophy of these treatment facilities, that emphasis client-centered care and evidence-based programming, dictate strict no use policies that when violated result in moral model, punitive measures.

Glisson (2007), speaking on the effectiveness of social service agencies as a whole, argues that agencies are only effective if they utilize best practices while

continually demonstrating prescribed practice models, involve positive and healthy therapeutic relationships between service providers and consumers, and provide ongoing availability, responsiveness, and continuity of their services. Harm reduction, as an evidence-informed practice, must be both accessible as direct practice and demonstrated as an agency framework in order to acknowledge and reinforce support of the approach for employees. If harm reduction is recognized, endorsed, and practiced at an organizational level, social workers are better positioned to utilize a harm reduction approach and implement harm reduction in their direct practice.

Glisson (2007) argues that implementation of evidence-based practices in a function of the social context of an agency, the norms, values, expectations, perceptions, and attitudes of members of the organization. The social context can encourage or inhibit the adoption of best practices and minimize the effectiveness of the agency and its practices as a whole, and in particular those that receive some or all of their funding from governments. Mancini and Linhorst (2010) suggest that in order for harm reduction to be effectively incorporated into community organizational settings, service providers need to be trained and socialized into new ways of practice and emphasize that harm reduction must fit with an individual or organizations established values and ethics or they will not be accepted.

Buccieri (2010) exploring street youth and service providers' perceptions of harm reduction as practice interventions at an agency level in Ontario, found that service providers often disagree on the effectiveness of harm reduction. A study by O'Rourke, Ruiz, and Allen (2015), explored how client-identified needs compared to agency-provided services in the context of harm reduction case management, and found that

while services were often aligned with client-identified needs, in six of nine service categories, ranging from pharmaceutical needs to housing, clients were more likely to receive agency responses related to their substance use in the form of unwanted treatment referrals and counselling services. O'Rourke, Ruiz, and Allen's study highlights the impact of service provider perceptions and agency social context on the effective implementation of harm reduction interventions.

Finally, in order to be implemented effectively, harm reduction philosophy, policy, programs, and practice must include the drug user in all aspects of harm reduction in order to support evidence-informed practice. Harm reduction recognizes the competency of drug users to make informed choices and understands that drug users have personal capacity to change their lives (BCCDC, 2011).

## **Conclusion**

Social work and harm reduction are compatible in supporting individuals through client-centered approaches that meet the client where they are at, and respect the individual's rights to self-determination (Vakharia & Little, 2017). Both social work and harm reduction have devolved, becoming less about social justice and more about maintaining their interventions within existing oppressive systems (Smith, 2012). It is not enough for agencies and service providers to simply adopt an evidence-informed practice such as harm reduction. Harm reduction, social work, and the organization are not mutually exclusive. The ambiguity of the term harm reduction, highlighted by Buccieri (2010) emphasizes the need for further dissemination of the term and associated discourse at an agency level.

Harm reduction and its compatibility with social work, is a regularly neglected and/ or absent topic in social work education. Social work students, while perhaps participating in elective courses on addiction or substance use, are unlikely to gain knowledge and skill on harm reduction philosophy, strategies, and skills in the classroom. The lack of in-class preparation impacts the social work field, where students becoming employees are left without guiding principles of working in a harm reduction framework in their social work roles.

Effective implementation of harm reduction involves an organizational culture that recognizes, endorses, and practices harm reduction at an organizational level (Glisson, 2007). The organizations commitment to harm reduction can therefore have a trickle down effect to social workers employed by the organization. Organizational culture supports employee knowledge and skill building in order to effectively implement evidence-informed practices.

### **Conceptual and Theoretical Framework**

Harm reduction focuses on reducing the harm associated with an individual's behaviour, rather than the behaviour itself. Harm reduction does not focus on an individual's substance use as separated from an individual's environment, rather harm reduction examines substance use at an individual, community and, broadly, at a systems level that includes the health, social, economic, and political risks associated with substance use. Harm reduction is supported by structural social work theory, that understands social problems, such as substance use, as being caused by broader systems issues that oppress some people and privilege others (Lundy, 2011). Harm reduction understands substance use as a symptom of social determinants of health, such as poverty,

education, employment, ability, mental health, and other aspects of an individual's wellbeing, and may be associated with a history of trauma and/or a traumatic event.

Harm reduction focuses on how an individual's environment may influence their substance use and the associated risks, compatible with critical ecological theory, highlighting the interconnectedness of individuals to each other and to our social systems and environments (Rothery, 2008). Rothery says this interconnectedness is further intertwined with an individual's reflection of their reciprocal relationship to others and to their environment. Critical ecological theory can support harm reduction at a community level and supports community-based harm reduction initiatives, while exploring the relationship between the individual using psychoactive substances and their community (Saloner et al., 2018). Trauma-informed practice supports harm reduction practice by recognizing an individual's potential trauma and acknowledging that the potential trauma may impact the individual's willingness and ability to enter into a therapeutic relationship (Knight, 2015). Trauma-informed practice is compatible with harm reduction, by reinforcing the need for a person-centered approach that understands the individual as the expert in their own life, capable of developing their own therapeutic goals with the support of the social worker (Levenson, 2017).

Further, harm reduction is fundamentally, a strengths-based approach, grounded in resiliency research that understands that all individuals have strengths that can be uncovered with the support of a practitioner, and supports the empowerment of the individual in making informed decisions about their health and their life (Saleebey, 2013). Harm reduction is an anti-oppressive approach to counter oppressive practices, specifically socio-economic oppression, that is initiated by the removal of injustices that

are consistently reproduced in everyday life and support inclusion (Burke & Harrison, 1998). Each of these conceptual and theoretical frameworks support harm reduction initiatives at a policy, program, and practice level.

As a human-centered profession concerned with individuals, families, and communities, Bigler (2005) insists social work and harm reduction fundamentally intersect by mutually respecting the dignity and worth of all individual, a commitment to the right of individuals to self-determination, an understanding of the impact of access to resources as social determinants of health, a commitment to social justice, an acknowledgement of an individual's social location, a strengths-based perspective, a commitment to evidence-informed practice, and through the utilization of collaborative interventions. Social work has begun to endorse harm reduction as an approach to psychoactive substance use as it fits well with social work professional values, client-centered, strengths-based approaches, and critical ecological systems theory (Bigler, 2005).

At a direct practice level, harm reduction is a trauma-informed, anti-oppressive, evidence-informed practice approach that supports an individual's right to self-determination and ability to make informed decisions about their substance use, their health, and their lives. While social workers and the organizations that they work within may indicate a formal or informal mandate that indicates support and commitment to harm reduction approaches, harm reduction and substance use literature falls short in exploring social work perspectives of harm reduction. In particular, how social workers and their respective organizations currently perceive harm reduction and how they

perceive the implementation of harm reduction in their direct clinical practice (Bigler, 2005; BCCDC, 2011; Karoll, 2010).

Given the limited literature related to harm reduction approaches as part of social workers' direct clinical practice with individuals who use psychoactive substances, this study explores the perception social workers' perceive harm reduction work and the implementation of harm reduction work when working with people, communities, and populations who use psychoactive substances.

## **Methodology**

### **Purpose of Study**

Gaining the perception of social workers working with individuals who use psychoactive substances use in rural Central Ontario can further the development of harm reduction work as evidence-informed practice. Supporting social workers in how to further conceptualize and utilize harm reduction in their direct practice can support greater awareness of the barriers for people who use psychoactive substances in rural Central Ontario. This may lead to policy changes on a larger scale and emphasize the importance of social work involvement in harm reduction initiatives at a national level. Social workers are often situated at the front line of supporting individuals who use psychoactive substances, yet they may lack the knowledge, awareness, and skill to effectively implement harm reduction work in their direct practice with people who use substances in rural Central Ontario.

More research needs to be conducted to explore how social workers perceive harm reduction as evidence-informed practice for people who use substances in rural Central Ontario. Furthering the literature on the awareness of harm reduction at an

agency and service provider level may support increased adoption of effective harm reduction practice, support local agencies and organizations in developing their harm reduction implementation practices at an organizational level, result in greater dissemination of harm reduction practice for individuals who use psychoactive substances, and aid the Ontario College of Social Workers and Social Service Workers (OCSWSSW) and other social work regulatory bodies in the development policy directives and guiding principles for harm reduction work for registered social workers throughout Canada, and add to the discussion of harm reduction work as a critical and integral approach to ethical social work practice with individuals who use psychoactive substances.

A review of the literature on social work and harm reduction work as it pertains to individuals who use psychoactive substances reveals that, while social workers are employed in positions that complete harm reduction work, there is a lack of literature<sup>1</sup> on the perspectives of social workers' in completing harm reduction work and how this work is impacted by the organizations in which social workers are employed. In order to support greater awareness and engagement with social workers harm reduction work, this study explores social workers' perceptions of harm reduction and its implementation in their direct practice in rural Central Ontario through the use of semi-structured interviews.

The view of social workers contributing to harm reduction work in rural Central Ontario is a critical perspective needed to support current and future social workers in effectively delivering harm reduction within the organizations by which they are

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<sup>1</sup> Data sources included a search of the electronic databases available through Laurentian University library as well as a Google Scholar search. Key words included: agency, harm reduction, social work, social work education, psychoactive substance use.



employed and in doing so, support further integration between social work and harm reduction work, building on the literature that exists.

The study is not a comprehensive exploration of the organizations that employ social workers themselves, but rather a primary exploration of the perceptions of social workers who are completing harm reduction work in rural communities in Central Ontario.

### **Research Question**

What are social workers' perceptions of performing harm reduction work and in implementing harm reduction in direct clinical practice with people who use psychoactive substances in rural Central Ontario?

### **Research Goals**

The study was guided by four main goals:

1. To identify how social workers' perceive harm reduction work as part of their direct clinical practice in working with individuals in rural Central Ontario who use psychoactive substances.
2. To identify how social workers' in rural Central Ontario perceive the operationalization of their social work ethics, knowledge, skill, values, and clinical training in harm reduction work approaches.
3. To have an understanding of how social workers in rural Central Ontario operationalize harm reduction work within their role and in the context of the organization of which they are employed.
4. To identify how social workers' perception and perceived operationalization of harm reduction work fit with the social work world view/lens.

**Research Method**

Qualitative research is used to explore and understand meaning that individuals or groups give to a social challenge (Grinnell, Williams, & Unrau, 2012). A qualitative research approach was used as a means to explore how social workers perceive and operationalize harm reduction work with individuals that use psychoactive substances.

An interpretive phenomenological approach (IPA) was used throughout the research process with a goal of exploring the perception of social workers in defining and understanding harm reduction as a direct practice model and their perception of implementing harm reduction within their own practice in rural Central Ontario.

IPA is used for small sample sizes, utilizing purposive sampling, semi-structured interviews, with the researcher having an active role in the data analysis process (Smith & Osborn, 2003).

The complexity of this goal requires a flexibility that is not supported through quantitative research. This qualitative exploration can support the identification of effective harm reduction and social work intervention strategies to aid in staff development, organizational effectiveness, and support better client outcomes for individuals who use psychoactive substances in rural Central Ontario.

Seeking out social workers perceptions through semi-structured interviews allows for an interaction that deepens understanding or perception for both the participant and this writer. The questions are layered in such a way that they would be difficult to answer without thoughtful conversation as a means of information gathering that involves the participant's reality, the researcher's reality, and the mutual reality that is created and shared between them both (Grinnell, Williams, & Unrau, 2012).

Participants received verbal and written information (Appendix B) on the voluntary nature of their participation and their ability to withdraw from the study at any point in time prior to the results being aggregated and published. Participants were encouraged to ask questions prior to signing the Consent Form (Appendix C).

## **Ethics**

Ethics approval was granted by the Laurentian Research Ethics Board (REB) via ROMEO interface for approval. Recruitment and data collection commenced after REB approval had been received.

In supporting all ethical considerations, the researcher has previously completed the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2) online tutorial and received TCPS 2 certification.

## **Target Population**

Participants were social workers registered with the OCSWSSW and/or individuals who have completed a social worker degree and/or social service worker diploma program who were eligible for registration with the OCSWSSW or other Canadian regulatory social work body at the time of the interview. Participants included individuals who are currently working in rural Central Ontario in direct practice with individuals who use psychoactive substances.

Rural Central Ontario is defined, for the purpose of this study, as non-urban areas of Central Ontario that are part of large geographic catchment areas. Rural Central Ontario is often made up of many small towns that are not situated close to large urban areas, or have one more urban area within which most services and programming are operated from.

Participants were social workers working in a variety of different social work roles with a variety of different target populations. Target population refers to the dominant subset of individuals served by a particular agency, organization, service, or program. The target population can, in some cases, be quite specific, such as individuals who use intravenous psychoactive substances, while in other cases be quite broad. Participants worked in agencies with dominant programming related to mental health, substance use, AIDS, and pain management.

### **Recruitment**

The research sought a specific group of individuals in which to study, and for this reason, purposive sampling was used to recruit social workers who were registered with OCSWSSW or eligible for registration. Purposive sampling is used when a researcher wishes to purposely choose a specific sample (Grinnell, Williams, & Unrau, 2012).

Potential participants were contacted directly through email and provided recruitment information, inviting them to participate in the research study. Participants, following the interview, were encouraged to provide the researcher's contact information to other colleagues or social work peers whom may be interested in participating in the research. This encouragement to participants resulted in a type of sampling referred to as snowball sampling, which utilizes current participants to locate other potential participants of a particular group (Grinnell, Williams, & Unrau, 2012). Recruitment was also completed through online advertisement on the OCSWSSW website with a Recruitment Script for Phone/Facebook/Email (Appendix C) attached to the website.

It was challenging to locate social workers in rural Central Ontario, and in particular, locate social workers working specifically with individuals who use

psychoactive substances. Social workers employed in rural Central Ontario are often working in community roles based in one community and providing service to a large catchment area. For these reasons, the researcher encouraged snowball sampling.

A letter of information (Appendix B) was provided to all interested participants as well as all relevant contact information and potential participants were encouraged to ask the researcher questions about the study and their participation prior to agreeing to participate.

### **Sample**

In total, six participants were interviewed. The participants and myself arranged interviews in a way that was mutually agreed upon. While effort was made to complete interviews face-to-face with participants, all but one of the interviews took place over the phone. The face-to-face interview took place at the participant's place of employment, as requested by the participant.

### **Data Collection**

Data collection was completed through semi-structured interviews with participants. Interviews were approximately 25 – 60 minutes long, dependent on length of responses by participants. Participants were provided with the letter of information (Appendix B) and consent form (Appendix C) prior to participating in the semi-structured interview. All participants were asked to complete a short demographic questionnaire (Appendix D) as well as respond to the semi-structured interview questions (Appendix A) verbally. All signed consent forms, completed demographic forms, and handwritten notes will continue to be stored in a locked cabinet at the School of Social Work, Laurentian

University, Sudbury, Ontario. Data will be stored for a period of seven years and destroyed in 2024.

Participant interviews were recorded using Quick Time Player recording software. A third party professional transcriptionist transcribed interviews with all data de-identified.

### **Data Analysis**

Interpretive phenomenological approach (IPA) was used to analysis the data. IPA emphasizes research as a dynamic exercise where the researcher has an active role (Smith & Osborn, 2003). IPA understands that research involves two-stages of interpretation, the participant is interpreting the research questions through their lived experience, and the researcher interprets the participant's interpretation through their own lived experience (Smith & Osborn, 2003). Instead of the more popular method of bracketing, which seeks to set aside our subjective interpretation and biases in order to objectively focus on the research process (Creswell, 2014), IPA seeks to explore the subjective experience by embracing its existence and utilizing it as part of the research process (Smith & Osborn, 2003).

The decision to use IPA was based out of my close connection with social work and harm reduction, coupled with the belief that I am not able to bracket and set aside my subjective interpretation of the data. IPA supports structural social work approaches that understand the need to acknowledge our bias and subjectivity, with the belief that it can be minimized but not completely avoided.

IPA data analysis asks that the researcher immerse themselves as fully into the data as possible and place themselves, as deeply as possible, into the position of the

participant (Pietiewicz & Smith, 2012). The initial stage of IPA data analysis involved reading each transcript a number of times and to listening to the audio recordings of the interview a number of times (Pietiewicz & Smith, 2012). At this stage of analysis, I made short hand notes of my observations, reflections, and any other thoughts or comments. I wrote notes on the transcripts and used some high level coding to initiate the analysis.

Personal reflexivity is an important concept of IPA during the initial stage (Pietiewicz & Smith, 2012). In order to complete the analysis, I considered the ways that I incorporated my personal reflexivity characteristics and lived experiences into the interviews and how this impacted my rapport with participants. Being a social worker employed as a clinical supervisor, I found myself challenged to not ask leading questions in a motivational interviewing style. I found myself having difficulty not engaging in more opinionated discussion as a social work advocate of harm reduction work. My role as a clinical supervisor had me wishing to support clinical integration of social work and harm reduction for the participants and I had to continue to engage with my role as researcher and work to disengage from my supervision role.

The second stage of IPA data analysis involved transforming notes made in the first stage into emergent themes. Here I used large pieces of paper to provide visual support to the analysis and spent a great deal of time with the notes. I colour coded the interviews to support me in analysis. While spending time with the data I made separate notes and discussed the emergent themes with my supervisor and anonymously with my social work peer group. These discussions supported my reflection of the data collection and analysis.

The final stage involved exploring the emergent themes for relationships, clustering themes, and providing the clusters a descriptive label (Pietiewicz & Smith, 2012). This stage lasted some time and I continued discussing the relationships with my supervisor and anonymously with my social work peer group. Their questions supported the development of my descriptive labels.

### **Strategies for Validating Findings**

Memos collected in a researcher journal and researcher debriefing were used to support the validity of the data analysis (Creswell, 2013). In the process design, implementation, and analysis, memos were used to write out thoughts and experiences, consider differing concepts, categories, and their synthesis into major categories and associated concepts, as well as control feelings and meanings on a personal and professional level. Debriefing was used with my thesis supervisor and anonymously with a social work peer group, in order to provide an external check of the research process, an opportunity for catharsis, and to keep me honest (Creswell, 2013).

Member checking was utilized to reinforce my conclusions and support my discussion, highlighting some of my main themes and the connections and interactions between them.

### **Personal Reflexivity**

My employment experience has been largely based in work with individuals who use psychoactive substances. In past employment I have experienced challenges in understanding and implementing harm reduction strategies within an abstinence-based system of support services that is focused on use rather than individual goals. I have been employed in organizations without adequate clinical supervision and have been



challenged to integrate my social work education into my clinical practice, while balancing the needs and wishes of the organizational with which I am employed.

I have struggled with the perceptions of co-workers who feel that ceasing substance use is the only way to truly heal oneself from substance use, and who freely label individuals as addicts, a custom largely associated with Alcoholics Anonymous and derived from the moral and medical models. My current work is in a community mental health program in a clinical leadership role. My supervision learning underscores my desire to support the transition from learning to implementation and integration of social work education to practice approaches, such as harm reduction.

My employment and personal experiences have developed in me a passion for harm reduction as a philosophy, policy, and practice, and as the means to provide trauma-informed, client-centered, and resiliency-based approaches to client care. I am interested in how other service providers perceive harm reduction from a direct practice standpoint. I am curious as to whether agencies that identify harm reduction as their approach to treatment are doing so on a rhetorical level, or if the agencies provide a framework, education, and skill building to implement harm reduction and to evaluate the implementation within their agencies. I have an interest in working to further the literature involving harm reduction at an organizational and direct practice level. In my employment experience I have frequently witnessed people 'fall through the cracks' when their treatment goals are not abstinence based and when I felt harm reduction direct practice was not implemented in effective ways. I think that 'client-centered' care by organizations needs to be examined in relation to clinician privilege. Without exploring

our personal privilege at a clinician and organizational level, it is difficult to engage in meaningful, effective, and honest client-centered care.

It is my desire to explore these gaps and inefficiencies in order to inform practice, programs, and policy, and to support people in having access to evidence-informed, people-centered social work practice that allows them to make informed decisions about their substance use goals, their own health, and respects and values their right to self-determination.

## **Results**

### **Participant Demographics**

Participants were asked to complete a demographic questionnaire as part of their participation in the study. In total, six participants completed the interview. Of the six participants, four participants identified as female, woman, and/or cisgender woman, one participant identified as non-binary, and one participant identified as gender fluid/feminine of centre. Participants ranged from 27 to 55. Participants identified as Caucasian/Canadian; European/White; European/Italian/Indigenous (Mi'kmaq); Canadian; European; 7<sup>th</sup> generation Canadian of settler origins, with all participants identifying English as their preferred choice of language. Three participants indicated they had completed a BSW, two a MSW, two a Social Service Worker (SSW) diploma, and two had additional Bachelor of Science and Bachelor of Arts degrees respectively. All participants indicated eligibility for registration with the OCSWSSW with four participants actively registered at the time of the interview. Four participants identified their place of social work employment as primarily a community support services agency,

one participant as primarily mental health support services, with one participant employed in a health care setting.

### **Emergent Themes**

In analyzing the data, an overarching theme of stigma, associated with substance use and harm reduction, emerged. This overarching theme of stigma was highlighted within each participant interview in a variety of direct and indirect ways. Perceived, institutional, and internal stigma were all indicated within the data as impacting the perception and implementation of harm reduction work amongst social workers working with individuals using psychoactive substances.

Within stigma, three main themes emerged as impacting the perception and implementation of harm reduction work amongst social workers working with individuals who use psychoactive substance. These included, the social workers organizational culture and climate, the utilization and integration of social work as harm reduction work, and the clinical barriers that exist to implement harm reduction approaches in rural Central Ontario. Funding received by an organization for clinical programming and service was indicated as a main bridge in the relationship between organizational culture and clinical barriers, while clinical supervision, or the lack of, was indicated as a main tool to aid the relationship between organizational culture and social work as harm reduction work.

Organizational culture was aligned with sub-themes that included an organizations commitment to harm reduction and their use of formalized policy and procedure of harm reduction policy and practice.

Social work as harm reduction was further refined by indication of the use of generalist social work practice within social work employment roles and social work knowledge, skill, and value integration into social work position and employment role. A third theme of personal experience and self-reflection was added to this section, as it was indicated as a space in which participants reflected on themselves both as social workers and as harm reduction workers.

Finally, clinical barriers to the implementation of harm reduction in rural Central Ontario were indicated by the sub-themes of accessibility and availability of direct harm reduction programming and service.

### **Stigma of Psychoactive Substance Use and Harm Reduction**

Stigma was an overarching theme emerging from the data. It was referenced either directly (four) or indirectly (two), by all participants. The concept of stigma was embedded within and impacted both main and secondary themes. Perceived stigma, internalized stigma, and institutional and structural stigma, were all discussed by participants.

Perceived stigma is an awareness of the negative social attitudes, coupled with a fear of being discriminated against and feelings of shame by an individual. Internalized stigma refers to an absorption and acceptance of negative attitudes, beliefs, and feelings by stigmatized individuals themselves and about the community in which they belong while institutional or structural stigma refers to stigmatization of a group of people through policies and procedure (Canadian Public Health Association and Canadian HIV/AIDS Legal Network, 2017).

**a) Perceived Stigma**

One participant discussed stigma associated with individuals' accessing harm reduction programs and services in the community and the implications of that stigma in supporting individuals in accessing office-based services,

“I mean, like obviously there's a stigma behind it...behind accessing those services. Like, it's desperation and we are handing out, like, clean needles from our centre, and the centre has certain connotations on it that folks may be like, not wanting to come, which is why, like, outreach can be really important” (#2, p. 4).

Participants cited perceived stigma as impacting the capacity for them, as social workers, to locate individuals who use psychoactive substances, as the population is often hidden, particular in rural communities, where there is less of a 'community' of people who use substances.

Another participant stated, “How people use substances is different based on the type of community” (#3, p. 1), indicating that in more urban areas there is a street population while in rural communities, use is often hidden. This lack of visibility of substance use was reinforced by one participant who indicated that in areas of rural Central Ontario that support a large tourism economy, substance use, harm reduction, and support services are incongruent with the perceived prioritization of the tourist economy.

**b) Internalized Stigma**

One participant, discussing people who use psychoactive substances, highlighted the internalized stigma,

“...they didn’t think that they deserved any better than that because they were doing the things that they weren’t supposed to be doing. That they knew that those things were dangerous and that...and that they weren’t there for, um, that they didn’t deserve to be safe or they didn’t deserve to be happy” (#3, p. 6).

Internalized stigma is experienced not only with the individual using substances and dominant society, but also within the substance using population that they are a part of,

“...I think that is part of a larger social stigma that then becomes embedded even within those communities even among the communities, for example, that are using intravenous drugs. Um, like there’s...there’s an additional like shame and guilt to it that wouldn’t necessarily, um, be as prevalent among crystal meth users who are smoking, for example” (#3, p. 7).

### **c) Institutional and Structural Stigma**

Several participants explored and highlighted the institutionalized stigma that exists within the organizations by which they are employed, “There’s lots of stigma. I even think there’s stigma in our organization” (#4, p. 6).

Institutional stigma was highlighted as impacting the visibility of an organization, with one participant suggesting that an agencies lack of visibility in the community contributed to lack of individual awareness of programs and services,

“You know, like I said, I think there is some stigma in the organization around mental health and addictions, not just one or the other. I think, you know, um, we don’t even have our name...like, we have a small nameplate on the door that says we’re a mental health. Or, it’s actually back here I think. I don’t even

think it's on the front. No, it might be on the front. But you know, like, and maybe that's for privacy reasons and that's totally fine if that's the reason too, right. To support people's...their privacy around...I don't have that problem, but I think, you know, if people are really looking for help, where do they go? They don't know where to go in town" (#4, p. 10).

The same participant identified the particular need and organizational responsibility to support visibility of programming and services within rural communities,

"So I think we just need to be out there more as an organization. I know we are out there. People know who we are, but...I don't know. It's so hard in a small town I think. Because I think there's probably...I think there's still probably stigma in a small town" (#4, p. 10).

Another participant, employed at a pain management clinic, cited a significant change in approach by new physicians at the clinic, in comparison from physicians that had been employed at the clinic for some time, cited a correlation between physician education and reduced stigma,

"...the reason that's [stigma] lessening is because our doctors are becoming much more educated. Um, our doctors are becoming more educated on different opportunities for, um, how to deal with...with, uh, with pain, how to deal with addiction. Um, and so...and we also have a lot...we're having a lot more younger doctors. So, the doctors we find who are younger in my...well, in my experience, the doctors who are younger are *way* more hip to this stuff" (#6, p. 9) .

A different key informant, cited how the combination of perceived, institutional, and internalized stigma can create complex barriers to supporting individuals who use psychoactive substances,

“Um, and a lot of it I would say revolve around the stigma that, um, that comes from...just generally the community around people who are using psycho active substances and so, um, people...especially because I’m new, um, there is a huge...because of how people use substances are treated more generally within the community, people are really apprehensive about trusting me. Which I completely understand. Um, but I think that there are many organizations who treat people that use substances as if they are not of value. Um, as if they don’t have, um...that they are lacking dignity and that they’re lacking, like, this sort of integral human aspect and so people are really, um, 1) apprehensive about receiving services, but 2) also a lot of people that I see don’t feel, uh, as if they deserve safety, as if they deserve to make choices for themselves. And I think that’s a *huge* barrier in terms of engaging, um, harm reduction. At least with the populations that I’m working with.” (#3, p. 6).

Perceived, institutional, and internalized stigma were identified as a dominant themes throughout each interview, highlighting the extensiveness of the stigmatization of people who use psychoactive substances and towards harm reduction approaches to substance use. The stigma, while referenced as a foundational theme of the study, is much more complex, weaving its way throughout each theme, as both a causal and reinforcing factor.

### **Organizational Culture**



Participants discussed the ways in which the culture of the organizations that they are employed by support employee capacity to implement harm reduction perspectives, approaches, and practices. Organizational culture refers to the norms, expectations, and the way that things are done at an organization (Glisson, 2007).

Study participants indicated a lack of formalized harm reduction policy and procedure at the organization that employed them. Participants indicated a lack of both formalized policies and associated procedures related to the provision of harm reduction approaches and services, while expressing that their organizations were, generally and broadly, supportive of harm reduction initiatives. Participants indicated that while there was an informal approach by their organizations senior management teams to support employees in providing harm reduction practices, there lacked guiding policy or procedural directives. One participant expressed,

“It’s also, uh, a lot more informal so we don’t necessarily have the policies and procedures to back it up. But in terms of, um, what our supervisor and, um, ED are informally supporting, um, yes, very much so.” (#3, p. 5).

Participants, largely, presented with some confusion to the question of their organizations mandate including harm reduction, highlighting an apparent disconnect between organization policy and procedure and employee direct practice. When asked about organizational mandate, participants, largely, focused on organizational practice. One participant indicated,

“...we kind of go through all stages of change and galore. So we go from crime reduction to moderation to action. So it depends on what the individual that

engages the services of the agency is looking for. And that's kind...then we cater it to them that way" (#5, p. 1).

Organizational culture, as it relates to harm reduction initiatives and approaches in the organization, was identified as having two main subthemes. The subthemes included an organizations ongoing support and commitment to harm reduction, as well as, the training and learning initiatives offered by an organization.

**a) Organizational Formal and Informal Harm Reduction Support**

When asked whether their organization supported harm reduction, all participants indicated that their organization did, reporting that the organizations they worked for were engaged in harm reduction rhetoric and supportive of harm reduction approaches at a service level. Participants discussed the more informal ways that their organization supported harm reduction, which, generally, included their organization allowing them to do harm reduction work and practice in the communities that they serve. As one participant expressed, "They [the organization] wouldn't stand behind me. But in terms of going out and making those connections in the community and doing that...that work, they're very supportive of that" (#3, p. 3).

Participants cited disconnect between harm reduction support at the senior management level and front-line practice and clinical supervision, "Um, so my direct supervisor is really supportive of harm reduction. Um, however, uh, management kind of takes a, quite a hands off approach to supervision which has some problems" (#3, p. 9).

Participants were largely unable to articulate specific harm reduction work support at a senior management level. When asked to provide examples of support of harm reduction work at a senior management level, participants often cited the

acceptance of public health programming, such as availability of condoms, Naloxone, or safe injection supplies. Staff Naloxone training was often expressed as a means of support by senior management.

One participant highlighted that their organizations support for harm reduction was indicative of current available funding for harm reduction specific programs and indicated that their organizational direction within harm reduction changed according to what specific funding was available.

“...we received, kind of with the opiate crisis, received a bit of funding. But there's no actual mandate saying we have to do harm reduction. It's more because we're very client-centred and client oriented, meeting them where they're at, and then being able to say 'yes we can reduce harm by having a harm reduction approach'. We kind of engage in services that way, bridge the gap” (#5, p. 2).

In some cases, participants cited the informal nature of their organization's harm reduction policies and procedures as being a protective factor to ensure continued funding for service provision and mitigate reprisal from funders and the community at large. As one participant expressed,

“...because it's such a small organization and because we're constantly in fear of losing our funding, when we...we get a lot of one year contracts, um, or one year funding allotments, um, the management of the organization has not felt comfortable, um, being public about that support” (#3, p. 3).

Another participant indicated that while their organization was mandated to support harm reduction pain management support, the recommendation of the

organization was to refer individuals who use psychoactive substances to other “addiction” specific agencies, “It’s much more medical model. And then it’s also because...because we are primary care, it’s also, like, refer out. They recommend that we refer out to the addiction agencies if we have somebody coming in” (#6, p. 3).

### **b) Organizational Knowledge Building and Training Initiatives**

Participants highlighted the differences in knowledge and training initiatives within their respective organizations. Some participants indicated that they had been exposed to a number of different training initiatives relevant to supporting individuals who use psychoactive substances and harm reduction work, while others indicated that they had not had any training through their employing organization. Many participants, when asked about specific harm reduction work training, cited Naloxone, an emergency medication used to reverse the effects of opioid poisoning, as their only harm reduction training. Others indicated that their harm reduction work training involved the provision of harm reduction supplies, such as needle exchange equipment and safe inhalation kits.

None of the participants indicated that they had formally received information or knowledge building on what harm reduction work was and how to implement harm reduction work in their direct practice, outside of the public health specific Naloxone and harm reduction supply training and safe use.

“I wouldn’t say, like, specifically how to have the conversation. But we are given the education on safe needle...like, safe injection and what are good veins to inject in. What does it look like if you are injecting, how to support someone who is injecting potentially someone up, um, crack pipes, crystal meth pipes. What are safe ways of using them, diluting the drugs, things like that.

Um, we've had all of that education and we've kind of continued as new things arise, we've been given opportunities to...to continue deepening that education. But there's never been a moment where it's like it's 'OK, this is exactly how you have this conversation with someone'" (#5, p. 5).

Participants highlighted an informal approach to knowledge building in their employing organizations,

"I haven't had to seek information outside of...of work because the information has been readily there. So organizations such as CATIE, I talked about pamphlets earlier, Canadian Aids...CA...I think it's CATIE, I can't think of what it stands for, um, through them and a lot of their promotional information, um, and then through the Ontario...InfoOntario, their initiatives. I can find, like, vignettes posted online" (#1, p. 7).

With another participant citing online training resources that they have completed independently, "I've taken a couple, like, um, online courses, like, through...I took one through Vancouver Coastal Health ...recently that was really great. I really liked it. It talked more about the evolution of their harm reduction program...and what they're doing to support people in the community" (#4, p. 6).

One participant discussed how employees at their organization are often hired with the understanding that they are knowledgeable and skilled at harm reduction work, and that this assumption, coupled with a lack of formal training, leads to inconsistencies and a disconnect for client's accessing harm reduction support,

"...sometimes it can result in, like, a lack of training, especially when...when people say, like, 'hey, I need this'. It's kind of like 'oh, go talk to this person

about it' and it's very informal and I find that that can create a...a disconnect between workers in terms of where they're coming from and what perspective they're bringing to their work" (#3, p. 11).

### **Social Work as Harm Reduction Work**

Participants discussed their perception of harm reduction work as sharing the same values and ethics as social work. Participants indicated that harm reduction work as a "foundational belief" (#3, p.5). Participants were asked their perception of how they had learned to implement harm reduction into their direct practice work, and indicated a largely informal process. One participant indicated that learning came from colleagues talking about harm reduction and being open about how they integrate harm reduction into their social work practice.

#### **a) Generalist Social Work Practice**

When discussing the means in which they had learned to implement harm reduction approaches in their direct practice, all but one of the participants indicated that the implementation of harm reduction was akin to social work values and ethics and came naturally to their practice. "It wasn't something I had to bring into my practice" (#4, p. 8). Participants indicated that harm reduction existed around the client-centered approach to care and that the harm reduction aligned with social work as a foundational belief. One participant, highlighting this aligning, remarked, "Social workers have been doing harm reduction for ever" (#2, p. 5).

Participants discussed how they became knowledgeable of how to implement harm reduction and, for some participants, they felt that harm reduction aligned not only with their social work values, but with their personal values as well. Participants

discussed the informal nature of their learning, “ I think through the professional...through the professional support I receive through my workplace. Also...yeah, and in receiving that information, just knowing that it was in line with my, uh, personal values as well” (#1, p. 7).

While participants indicated that harm reduction education was not indicated as a formal component of their social work education, harm reduction education was something that they were able to locate, informally or indirectly, in their academic and employment work. One participant indicated,

“I would say that I have not received any formal training academically. Um, although I did cater a lot of my own studies to, um, harm reduction literature. So, I got information, I just...it wasn't part of my formal education. Or at least wasn't a standard aspect of my formal education, cause no one else received it” (#3, p. 8).

Another participant voiced, “Yeah, so I mean, just by...by the way that my colleagues were implementing it, um, and talking about it and being so open about how you implement it. I think it came kind of naturally...” (#2, p. 5).

Generalist social work practice was, frequently, discussed in conjunction with the integration of social work knowledge, skill, and value integration.

### **b) Social Work Knowledge, Skill, and Value Integration**

Participants discussed, informally, the integration of Social Work knowledge, skill, and values as it pertained to their perception or harm reduction and it's implementation. Participants often felt that they had not had specific harm reduction education or tools to operationalize their learning into harm reduction work, yet

referenced knowledge, skills, values, and discourse when asked about their learning histories,

“...I guess probably...I’m going to use the assumption it’s probably just from my background, like, being a social worker and having the education of approaching a therapeutic session or, um, kind of having the holistic perception of community and everything like that. And then just, I don’t know I might...I’m my authentic self where I’m compassionate towards whatever the individual is going through and I just...I just talk to them!” (#5, p. 6).

Participants discussed the client-centered nature of harm reduction work as supporting their social work. One participant expressed,

“...cause I try to be as client-centred as I can. And I think that’s what harm reduction is. It’s about meeting the individual where they’re at with, you know, their addiction and supporting them as best we can until their ready to, um, either go to treatment or whatever they need to do” (#4, p. 9).

Participants, generally, voiced an agreement towards a generalist social work practice that allowed them to provide harm reduction work without specialized training. Participants felt that their social work education, whether Bachelor or Masters level, well equipped them to work within a harm reduction framework. One participant indicated that their harm reduction learning was a formal aspect of their Master of Social Work education.

While a generalist social work perspective was indicated, to some extent, by all participants, one participant expressed reluctance to work with people who use



psychoactive substances around their substance use, “Well I mean, we just wouldn’t consider me to be the best person specifically for getting rid of an addiction” (#6, p. 7).

Overall, participants indicated were able to integrate social work knowledge, skills, and values, into their harm reduction work. Participants discussed that the social work lens provided them a foundation upon which to complete harm reduction work and they expressed a comfort in this, knowing that the work was, largely, within their scope of practice as social workers. Participants acknowledged a lack of formal integration work between their social work education and harm reduction work within their current roles, however indicated that they were able to informally integrate the skills through modelling of other social workers doing harm reduction work and utilizing social work knowledge, skills, and values.

Participants, while using their social work lens, perceived a variety of clinical barriers in their ability to implement harm reduction.

### **Clinical Barriers to Harm Reduction Work Implementation in Rural Central Ontario**

Participants identified a number of clinical barriers that they perceived as impeding their ability to implement harm reduction work. Participants cited lack of availability of harm reduction programming and services as well as lack of access to the available programs and services as major clinical barriers. Barriers are defined as issues that impede the effective access of programs and services to the individuals, populations, or communities that those programs and services are meant to serve. Availability pertains to the program or service existing in the first place, while access is more specifically, that the program can effectively serve the individual, population, or community that it is meant to.

The accessibility and availability of programming and services as a barrier to harm reduction approaches to direct practice was a foundational theme amongst participants. Availability and accessibility of programs and services often overlap, with clinical barriers that represent both a lack of existing service and a lack of access. More generally, a lack of availability constitutes a lack of accessibility.

**a) Availability**

Availability of harm reduction programs and services was a clinical barriers discussed by several participants. Participants indicated that there were often gaps in harm reduction programs and services. Availability included inadequate programming and services and inadequate staffing for programming and services.

**i) Inadequate Programming and Service**

Participants cited that there were many gaps in programming. The gaps were often associated with a lack of outreach programming and services. This lack of funding for specific outreach service was indicated as a major service gap for many participants. One participant expressed the challenge in providing office-based services within a large catchment area, “So, for my program, I’m stuck doing office work...working in the office in such a large catchment area. People have to come to me basically” (#1, p. 2).

A second participant further evidenced the need for outreach services within large geographic regions and emphasized the lack of harm reduction services, stating, “The bus services aren’t great either and so it’s hard for folks to come to us, and it’s also kind of hard for us to go to them. And so just the hugeness of the region makes it...poses a big challenge. Especially when only one or two agencies are doing that harm reduction work” (#2, p. 4).

ii) Inadequate Staffing

For some participants, certain employees at their organization provided harm reduction work, and there was an indicated exclusivity to harm reduction work. There was an indicated that harm reduction work was specific to substance use work and that knowledge and skill to implement harm reduction work was contingent on what an employee's role was within an organization. The specification of harm reduction programming created barriers related to long waitlists when referring clients for addiction based services with participants citing a need for increased programming and staffing.

One participant described the challenges of referring to substance use specific services, stating,

“So, um, so where I work there is an addiction services organization, um, and they need more staff. That is a massive problem. It's hard for us to get, um, it's hard for us to get word to them. It's hard for them to get back to us in a timely manner, just because they have not got enough people” (#6, p. 3).

**b) Accessibility**

Accessibility of harm reduction programs and services was indicated by all participants and cited as a major clinical barrier to the provision of harm reduction work. Participants cited transportation, geography and physical office location, hours, age constraints, along with inadequate staffing, organizational procedures, and length of service as barriers to accessibility.

i) Transportation

All participants cited very vast catchment areas and a lack of transportation as being major barriers in the implementation of harm reduction services. The catchment

areas for which they are providing service are geographically large, making it challenging to reach all service users without the utilization of large amounts of time along with large mileage expenses. One participant expressed, "In all honesty we don't service that entire area because, um, we just can't" (#3, p.1). One participant indicated that only some programs at their agency provided mileage expenses and that they were still capped after reaching a certain number of kilometers. One participant (#6) discussed that the lack of public transportation created risk of individuals driving while under the influence of a psychoactive substance in order to access support services.

"...this is a very vehicle bound area. You cannot walk. You have to drive wherever you're going to go. And so what it means is that, um, if people are using it, it's...you know, they're either driving high or.. they're either driving under the influence or they're driving with somebody else who hopefully isn't under the influence" (#6, p. 2).

## ii) Geography and Physical Office Locations

Several participants discussed that their agency or program catchment areas were made up of very small towns, with large areas having no physical office location. There was indication that the lack of physical office locations makes it difficult to access individuals that live in outlying areas, even with outreach approaches to service provision. "...there's just not enough time to cover all of that area" (#2, p. 1). Further, one participant highlighted the need for outreach staff to be able to locate individuals for the purposes of outreach, indicating that this is a challenge given the hidden nature of substance use in rural areas. One participant indicated that, "outreach within those different communities and just how huge it is, has to be very different and resilient" (#3, p. 1).

One participant discussed their work as a mobile outreach worker, supporting service provision across their catchment area, providing harm reduction supplies and naloxone training to service users at their place of residence. The participant indicated that while the service supports greater access, there are still barriers. “..transportation is a main barrier. Um, and then the other barrier I perceive is just not having enough resources in the smaller communities” (#5, p. 1).

iii) Hours of Operation

Participants discussed the need for increased hours of operation in order to support accessibility. One participant indicated the need for around the clock operations in order to provide access and cited limitations of not being able to offer evening or weekend support.

iv) Age Constraints

Another participant discussed age as a factor when referring out to specialized substance use services and expressed that she is unsure of how to support young people under the age of 16 requesting substance use specific supports.

v) Organizational Procedures

The agency harm reduction procedures were also cited as a barrier in providing accessible harm reduction programming. One participant discussed how the organization they work for is not highly visible from the outside and that it is a lengthy process for someone to retain harm reduction supplies.

“I find there’s a lot of barriers in this agency, uh, to get harm reduction. First you have to know that it’s here. We don’t advertise. Second, you need to go to

the second floor and then talk to someone through a window, and then they have to go and get someone who then takes your order, basically, goes and gets what they want” (#4, p. 2).

Accessibility of harm reduction programming and services had direct implications to social workers ability or inability to implement harm reduction work. Specifically, harm reduction work that utilized a client-informed, trauma-informed, strengths-base, and anti-oppressive approach. Accessibility requires key aligning with client-centered principles or ‘meeting the client where they are at’, both figuratively and literally.

See Figure 1 below for a visual summary of findings.

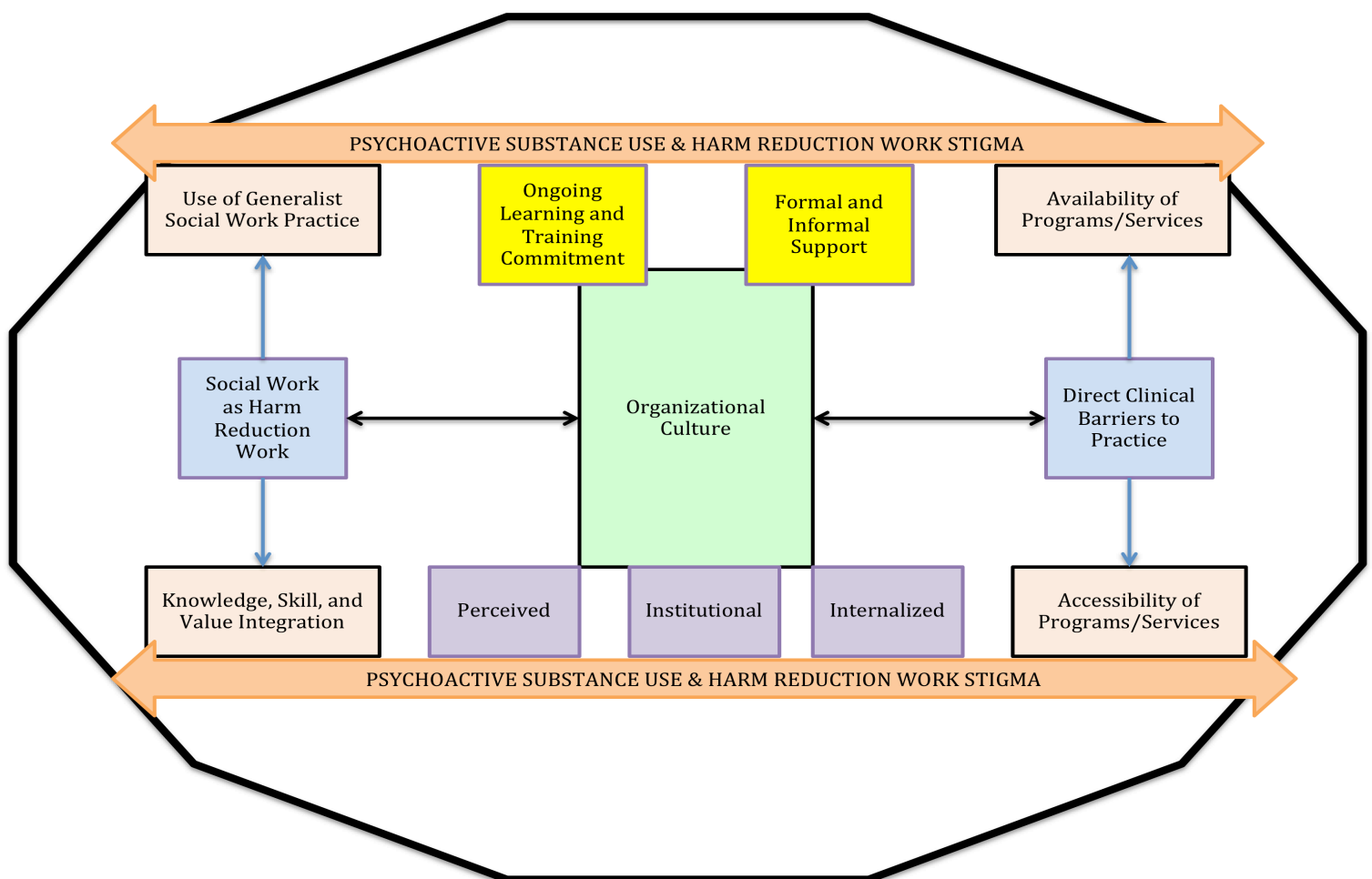


Figure 1: Summary of Findings

## **Discussion**

This exploratory, qualitative study explored how social workers' perceive harm reduction how they perceive the implementation of harm reduction in their direct practice with people who use psychoactive substances in rural Central Ontario. Results support advancement in understanding of social workers' perception of harm reduction and how their perception translates into direct practice with the individuals that they work with, as well as the barriers that exist and impede that implementation. This section seeks to analyze the findings of the study and contextualize them within the literature related to harm reduction, social work, and organizational culture. A short summary of findings is provided, followed by a discussion of each major theme. Implications for social work research, policy, and practice are offered, as well as limitations and a conclusion to the study.

### **Summary of Results**

Results from the analysis indicate that stigma is, in 2019 still overwhelming. It was the major theme among this study's respondents. Stigma associated with psychoactive substance use, individuals who use psychoactive substances, and harm reduction programming contributes to substantial barriers by those seeking out support for their substance use, as well as organizations and social workers working to support individuals who use substances. Stigma exists at a structural level, is institutionalized in our political, economic, and social systems, impacts provision of community services and programming, and also produces clinical barriers such as access and availability of services. Stigma is perceived as a clinical barrier to both those providing harm reduction

work, as well as internalized by individuals that use psychoactive substances, resulting in a reinforcement of stigma at both ends.

The results of the study highlight the role that organization culture plays in engaging and supporting social workers to align with harm reduction work in their employment roles, as well as the clinical barriers that are created that impact the ability for social workers to provide harm reduction approaches and programming. Organizational culture is directly impacted by political, economic, and social structures that support or impede organizations from providing evidence-informed, long-range, sustainable substance use programming. These social structures are influenced by stigma associated with psychoactive substance use and harm reduction approaches that often translates into a lack of adequate funding for programs and services. A lack of adequate funding translates into a lack of available and accessible programs and services to support individuals who use psychoactive substances and the provision of harm reduction approaches to support individuals, populations, and communities impacted by psychoactive substance use.

Participants discussed that the knowledge, values, ethics, and skills inherent in their work as social workers was the foundation upon which they perceived the implementation of their harm reduction work. Participants saw harm reduction work as an extension of their role and identity as social workers, and utilized their social work educations in supporting individuals who use psychoactive substances using harm reduction approaches.

The next section will seek to further analyze the major themes of the study and contextualize them within the topic literature.



**Institutional, Perceived, and Internalized Stigma**

Stigma of psychoactive substance use, individual's who use psychoactive substances, and harm reduction approaches is evident throughout the results of the study. The study found the social workers are largely aware of this stigma, as it translates and connects to their direct practice harm reduction work, however may not be as aware of the hierarchical nature of stigma and the ways in which it is disseminated through their employing organizations and their role as social workers.

Stigma associated with psychoactive substance use and harm reduction is implicated at a systems level, where policies and political discourse continue to reinforce the moral model, the disease model of substance use, or a combination and intersection of the two, that places the onus of substance use on the individual to either change behaviours or receive treatment for their substance use, rather than addressing the underlying issues that contribute to substance use in rural communities. The implication of moral and/or disease models of substance use distracts from the real structural, systems issues that cause or exacerbate the issues that individuals who use psychoactive substances may face within their communities (Souleymanov & Allman, 2016).

This implication of moral and disease models of substance use at a structural/systems is spread to social service organizations that are given the responsibility of treating substance use in the community through treatment modalities where success continues to be equated with a reduction in use. This continued desire to reduce or cease substance use supports abstinence-based approaches to substance use and neglects to acknowledge and understand substance use through a critical ecological lens that understands that, "harm reduction is an alternative approach to addressing the

failures of incarceration and medicalization as solutions to the personal and societal problems associated with drug use” (Bok, 2008, p. 3).

The study illustrates disconnect between the harm reduction programming and services happening at a front-line level, social work direct practice, and the policies and funding that support these programs. The organizational culture as well as social work, has a role in supporting the connection between these two paradigms, or conversely, can have a role in reinforcing the structural stigma. The study found that social workers often perceived their organization as being supportive of harm reduction work, however were accepting of this support being informal and were largely unable to articulate the ways in which their organization was supportive of harm reduction work outside of verbal permission to complete harm reduction work and specific programming initiatives.

### **Harm Reduction Work and Organizational Culture**

The lack of formalized policies and procedures amongst the participants' places of employment identifies a lack of framework when it comes to supporting social workers to integrate harm reduction into their social work practice. It seems that rather than implement harm reduction into their direct practice, social workers have the capacity to integrate harm reduction into their direct practice using their social work lens. The lack of clarity around harm reduction as an approach to direct practice may be a result of the public health approach to harm reduction, that frames harm reduction as specific programming rather than an overarching way of supporting a client. The disconnect arises from social workers trying to make sense of their harm reduction work and not identifying or acknowledging the relationship between social work and harm reduction. Integration of social work and harm reduction as direct practice may be supported

through more formalized agency mandates and policy initiatives that promote the integration of harm reduction into direct practice in meaningful ways.

As argued by Glisson (2007), implementation of evidence-informed practices is contingent on the social context of the organization. The organization must establish norms, values, expectations, perceptions, and attitudes that are generalized across the organization. Without concretely establishing social context that addresses the evidence-informed practice, implementation will not be effective or sustainable. When organizations fail to provide the employee a foundation upon which to place their direct practice, the effectiveness of the organization, its programming, services, and practices, decreases as a whole. When harm reduction is recognized, endorses, and practiced at an organizational level, through policies and strategic planning, employed social workers are provided a framework on which to build their direct practice. As suggested by Mancini & Linhorst (2010), harm reduction is more effectively incorporated in organizations when it fits with the established, formal and informal, values and ethics of that organization and its employees.

### **Social Work as Harm Reduction Work**

Harm reduction, as an approach to supporting individuals who use psychoactive substances, supports a person-centered, strengths-based approach. Harm reduction aligns with the critical ecological social work approach that understands human problems are, in many ways, caused by a complex relationship between psychological, social, economic, political and physical forces (Rothery, 2008; Pardeck, 2015).

The OCSWSSW Code of Ethics highlights the responsibility of the social worker to maintain the best interest of the client, respect the intrinsic worth of all persons, and

advocate change in the best interest of the client, society, the environment, and the global community (OCSWSSW, 2008). The OCSWSSW Code of Ethics, in conjunction with Standards of Practice, understands that social workers, “respect and facilitate self-determination in a number of ways including acting as resources for clients and encouraging them to decide which problems they want to address as well as how to address them” (OCSWSSW, 2008, p. 9)

Social workers, armed with the social work worldview, can support work in harm reduction by utilizing their social work knowledge, skill, and experience. While harm reduction is often positioned within a public health domain, social work is positioned effectively to support harm reduction philosophy, programs, and practice for individuals who use psychoactive substances (Bok & Morales, 1999).

Social workers may best support harm reduction, first, recognising their capacity, and by bringing their ‘tools’ to the table and collaborating with public health approaches to harm reduction work. Social workers clinical skills can be used critically, to support better wellness outcomes for individuals who use psychoactive substances, while social work ethics of advocacy, outlined in the OCSWSSW Code of Ethics (2008), support the ongoing advancement of harm reduction work.

Social workers are, by and large, learning harm reduction work by doing, by modeling the direct practice of their colleagues and pushing forward to support the needs of the individuals and communities that they serve.

Social work education can assist in aligning social work and harm reduction work by greater incorporation of harm reduction knowledge and skill building within social work academics (Bigler, 2005).

The OCSWSSW can more broadly support the alignment of social work as harm reduction work by incorporation of harm reduction into the Code and Ethics and Standards of Practice.

Social work is, overwhelmingly, harm reduction work. Social workers can be supported to do harm reduction work by reflecting on the knowledge, skills, experience, and social work worldview that they already possess. Social work generalist practice is an effective tool to support transferability of social work knowledge, skill, and experience, as discussed below.

### **Generalist versus Specialist Social Work Practice**

The results of the study highlighted social workers perceptions of general and specialist social work practice. There was an overarching opinion from participants that the social work lens supporting the perception and implementation of harm reduction work. Interestingly, a number of participants indicated that the integration of knowledge and skill to harm reduction work was relative to the role that the social worker had within their organization. The views were somewhat opposing, with participants indicating the capacity to learn harm reduction work and correlating it with social work, but only in the context of the specific or specialized position.

These views, in many ways, are reflective on institutional stigma related to psychoactive substance use, people who use psychoactive substances, and harm reduction work. They reinforce the idea that harm reduction work is niche or specialist work. Moral judgements of substance use, met with disease model implications to treatment, support the idea that a specialized service and clinician is required to support individuals who use psychoactive substances. While there is continued discussion on what the causes of

problematic psychoactive substance use or 'addiction' are, harm reduction work does not require a cause and is not a form of treatment in and of itself.

This perception of harm reduction as a specialized approach to substance use creates deeper barriers amongst programs with an already large service demand. This difficulty highlights a need to support social workers to integrate their social work approaches into direct practice in knowledgeable and skilful ways.

Coady and Lehmann (2016) emphasize that the generalist perspective of social work practice is required in order to ground any specialization in direct practice. This is particularly true with theories and approaches that have been developed outside of the social work profession and when working with individuals with complex needs (Coady & Lehmann, 2016).

The current trend in social work and amongst social service organizations is to divide the social services into specialized units and functions, creating specialized and specific services and requiring specialized social work knowledge and skill (Murty, 2005; Perlinski, Blom, Moren, & Lundgren, 2010). This promotes specialized social work that creates boundaries amongst social workers, who are led to believe that their knowledge, skill, and experience are not transferable to other populations, locations, or communities. Specialized social work promotes gaps in service delivery and lessens the broad reaching lens of social work. Social workers may feel that they are unequipped to work with particular people or communities based on the perception that they are missing some knowledge or skill building that was largely unavailable in the first place. Further, specialized social work may distance specialized clinical social workers from supporting other roles such as research, policy, and advocacy.

**Clinical Barriers to Harm Reduction**

Clinical barriers, by way of availability and accessibility of programming and services, are by no means a new phenomenon. Organizations and their employees are in a constant state of instability, particularly given the political climate and organizations must weigh the service and funding frameworks placed on them by structural system against the needs and realities of the population they serve. Social workers can be used by organizations to support this balance, however social workers must be met with an organization that priorities its organizational culture and utilises tools to ensure that social workers have the tools they need to effectively and formally integrate their social work lens into harm reduction practice.

Generalist social work practice is particularly important when it comes to the delivery of programming, including harm reduction work, in rural communities. Gaps in service provision are only widened when rural social work is met with social work specialization.

As indicated by participants, clinical barriers in rural Central Ontario, are often a result of large geographic catchment areas where the needs are impossible to meet with many social workers not receiving mileage to cover the costs of transportation. Often the costs of transportation are not allocated in funding formulas or caseload benchmarks, with organizations needed to utilize a large part of their funding in order to support outreach services (CMHA Ontario, 2009).

Social workers indicate that progressive outreach services are required in order to meet the needs of the individuals and communities, yet how do social workers promote the increased costs associated with outreach services. Social workers doing harm

reduction work are exploring progressive ways to provide outreach services and perhaps more creative exploration is required in order to shape these programs and services from the bottom up. One study, from Atlantic Canada, explores the integration of harm reduction services and approaches into mainstream health services in non-urban areas, in order to improve access to programming (Parker, Jackson, Dykeman, Gahagan, & Karabanow, 2012). This would also support continuity of service, which is evidenced as fragmented in rural Central Ontario communities (CMHA Ontario, 2009).

While clinical barriers to harm reduction are often a symptom of structural and systems level challenges that include inadequate funding for harm reduction work, social workers are aware and knowledgeable of the clinical barriers and working to support filling the gaps using their generalist, community-based social work practice. Social workers can use their social work worldview to advocate for programming and services that are available and accessible to individuals who use psychoactive substances and can work to develop creative and progressive outreach strategies that by exploring their professional relationships with main stream health care services.

### **Implications for Future Research**

The study is by no means an exhaustive exploration of social workers' perceptions of harm reduction work and implementation of harm reduction work, however the study serves to broaden the current social work and harm reduction work literature in the context of rural Central Ontario.

The following sections are implications, based out of the current study's results and discussion, for future research. The implications include research to bridge the connection between organizational culture and social work as harm reduction work, as



well as increasingly progressive research into the intersectionality of harm reduction and the intersectionality of stigma as it pertains to harm reduction.

### **Clinical Supervision**

Social workers working within rural communities have an impetus towards generalized social work practice that perhaps eclipse that of their urban employed social work peers. Future research might explore the role of clinical supervision for social workers working in rural communities.

The results of the study highlight a need to further explore the relationship between organization culture and social work as harm reduction work. Studies have explored the importance of social work and clinical supervision in supporting the integration and acquisition of social work education into direct practice (Bogo & McKnight, 2005). Bogo & McKnight, 2005, indicate, "It [clinical supervision] is a primary vehicle through which agency accountability is achieved" (p. 51), highlighting the role of supervision in carrying out an organization's mandate and purpose. Clinical supervision is indicated as a bridge between organizational mandates, values, and culture, and direct clinical, front-line work. Exploring the perceptions of harm reduction of social work supervisions and how they support harm reduction, balancing organizational and clinical need, would aid in a more developed discussion of social workers perception of harm reduction and the implementation of harm reduction in their direct practice.

At a social work, social justice level, Asakura & Maurer, 2018, indicate the use of clinical supervision in supporting clinical social workers' incorporation of the commitment to social justice into social work direct practice. Research into clinical supervision as it pertains to harm reduction may better support organizations in

identifying effective clinical supervision to support more effective service delivery, better integrate social work as harm reduction work, and support an increased social justice lens within direct practice social work roles.

### **Intersectionality of Harm Reduction and Harm Reduction Stigma**

Several participants discussed how individuals who identify with trans gender orientation use harm reduction program supplies to inject hormone medication. The participants indicated clients from the trans community were utilizing the safe injection supplies at their organization for the purpose of medication. Participants reflected that harm reduction, safe use training does not prepare them to effectively educate and support these individuals.

Further research into the intersectionality of harm reduction work, particularly as it pertains to the trans community may be useful in finding ways to more effectively support this community and better meet their harm reduction needs. This research would also support ongoing literature on the intersectionality between health care and harm reduction, outside of psychoactive substance use, and marginalized populations.

The intersectionality of stigma, as it pertains to individuals who use psychoactive substances and harm reduction work, is also an area to be further explored. Specifically, the interaction between intersectional stigma and harm reduction work by social workers. Further research may explore how social workers become aware of stigma and how they utilize their direct practice to challenge stigma at a structural and institutional level.

### **Harm Reduction Work by Other Professions**

While the study centered on social workers and harm reduction, a large number of individuals completing harm reduction work are not social workers. The perception those

completing harm reduction work that do not identify as social workers is also important. Research to explore how other professions perceive harm reduction and the implementation of harm reduction in direct practice would provide a greater context within which to place the role of social workers within harm reduction work.

### **Implications for Policy and Advocacy**

In keeping with the ethics of social work and the commitment to social justice, implication for policy and advocacy will be explored.

The study highlights the impact of structural and institutional stigma on organizational culture, harm reduction work, and clinical barriers to harm reduction work. Advocacy lies not only in addressing gaps in the availability and accessibility of harm reduction programming and services, but in pushing for policy changes that align with harm reduction work. Harm reduction work does not align with criminalization approaches to psychoactive substance use. Harm reduction policies approach psychoactive substance use from a critical ecological lens that contextualizes psychoactive substance use through an intersectional and structural lens. Harm reduction policies are person-centered and respect individuals' rights to self-determination. Harm reduction policies are trauma-informed and support resiliency.

### **Implications for Social Work Practice**

The study explored social workers' perceptions of harm reduction and the implementation of harm reduction work in their direct practice. Results of the study indicate that implementing harm reduction work effectively in direct practice is a complex process. As previously highlighted by Social workers, overwhelmingly, understand that their role as social workers aligns with harm reduction work with

individuals who use psychoactive substances. Social workers utilize generalist social work practice to integrate their social work education, knowledge, skills, and values to support the delivery of harm reduction work with individuals, populations, and communities. However, social workers benefit from clinical supervision to bridge the gap between organizational culture, including organizational policies and procedures, and social work as harm reduction work. Clinical supervision supports the connection of the social worker not only to their organization, but further, to their work as a social worker, in whatever role they are employed in. Organizations can benefit from having adequate and skilled clinical supervision that supports the integration of social work knowledge, skills, and values into the direct practice roles of social workers employed at the organization.

Social workers can reciprocally, benefit the organizational culture by reinforcing a social work and harm reduction work lens that aligns with formal or informal mandates. It is in an organization's best interest to support formal policy development of harm reduction policies that support this alignment and are based on knowledge, skills, and values that also align with the regulatory bodies of their employees.

### **Limitations**

Several limitations have been identified for this study, including sample size and diversity, and recruitment techniques.

The sample size of the study was limited to six participants due to time constraints of the research and the need to complete the interviews. The small sample size, while reflective of several rural locations in Central Ontario, is not representative of all rural communities in Ontario. Specifically, small rural Indigenous communities are not

represented in the sample. The 'ruralness' of the study is an ambiguous term, as there are varying degrees of what defines a rural community in Central Ontario. Many rural communities do not have access to any substance use support, with support requiring even greater travel than is indicated in the current study. While some of the findings may be generalized to these communities, it would be ignorant to assume that the findings are consistent with that of social workers and/or rural communities that are more deeply isolated, with fewer substance use and harm reduction organizations, programming, and services.

The diversity of the sample is another limitation. The sample may not be reflective of the cultural diverseness of rural Central Ontario, particularly in relation to Indigenous organizations. All study participants were employed at non-Indigenous organizations.

Finally, in reflecting on recruitment processes, there may have been more effective ways of ensuring greater participant recruitment and greater diversity within the sample. Reaching out to social workers employed at markedly rural organizations and communities may have yielded a sample that was more reflective of the 'ruralness' of Central Ontario.

## **Conclusion**

This qualitative study explored the social workers' perceptions of harm reduction and in implementing harm reduction in their direct practice with individuals who use psychoactive substances in rural communities. Knowledge of social work perceptions of harm reduction is a relatively unexplored topic in social work literature, and in particular, in rural Central Ontario communities. While there has been progress in the knowledge of

how social workers can implement harm reduction into their direct practice with individuals who use psychoactive substances (Vakharia & Little, 2017), there remain questions on how this implementation is perceived by social workers within the organization the social worker is employed.

The study suggests that participants are very knowledgeable of harm reduction philosophy and are able to locate and integrate harm reduction work with their social work knowledge, skill, values, and overall worldview. Participants highlighted the impact of stigma on their work and on the lives of the individuals that they worked with, however had difficulty utilizing a social work approach in challenging this stigma outside of their direct practice. Integration of social work skills to harm reduction work is indicated as a largely informal process that relies on modeling by coworkers and self-directed learning and knowledge building.

Participants indicated that while the organizations for which they were employed were supportive of harm reduction, they were unable to articulate concrete or formalized organizational support for harm reduction work outside of having the informal permission to do so. Organizational culture was found to have an impact of participants' ability to integrate their social work with harm reduction work in ways that effectively support advocacy and address gaps in service availability and accessibility.

While this study is in no way exhaustive, the study serves to broaden the literature of social work and harm reduction work within organizational culture and continues the conversation on the need for social workers to draw on their social work worldview, and the commitments to the OCSWSSW Code of Ethics, to challenge stigma at a direct

practice and organizational level and advocate and progress harm reduction work for individuals who use psychoactive substances in our rural Central Ontario communities.

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## Appendices

### Appendix A: Semi-Structured Interview Questions



#### Harm Reduction with People Who Use Psychoactive Substances: Social Workers' Perceptions in Implementing Harm Reduction in their Direct Clinical Practice in Rural Central Ontario

1. What size is the geographic area that your serve?

Probe: Do you perceive any barriers to services based on the size of the geographic area in program delivery?

If yes: What are the barriers?

If no: Go to question 3.

3. What does your agency mandate say about harm reduction?

Probe: Do you perceive harm reduction as being supported by your agency?

If yes: In what ways is it supported?

If no: Go to question 4.

4. How would you define harm reduction?

Probe: How would you explain harm reduction to one of your clients?

5. Is harm reduction part of your social work direct practice with clients who use psychoactive substances?

If yes: In what ways?

If no: Go To Question 6.

6. Do you perceive barriers to using harm reduction as social work direct practice with people who use substances?

If yes: What are the barriers?

If no: Go to Question 7.

7. Do you perceive barriers to using harm reduction as social work direct practice with people who use substances in rural Central Ontario?

If yes: What are the barriers in rural Central Ontario?

If no: Go to question 8.

8. Have you ever received, harm reduction education/training academically, or professionally?

If yes: From who, when and what type?

If no: Go to question 9.

9. How did you become aware /knowledgeable of how to implement harm reduction in your direct clinical practice with clients?

10. Do you perceive the organizational culture of your agency as impacting your ability to utilize harm reduction in your direct practice in rural Central Ontario?

If yes: In what ways?

If no: Go to question 11.

11. In what ways might the organizational culture of your agency better support your awareness, knowledge, and ability to utilize harm reduction in social work direct practice in rural Central Ontario?

**Appendix B: Letter of Information**

Harm Reduction with People Who Use Psychoactive Substances:  
Social Workers' Perceptions in Implementing Harm Reduction in their Direct Clinical  
Practice in Rural Central Ontario

Dear Colleague:

I am a Master of Social Work student in the School of Social Work at Laurentian University. I am seeking registered social workers and/or individuals who have completed a social worker degree program who may not currently be registered by the Ontario College of Social Workers and Social Service Workers (OCSWSSW) or other Canadian regulatory social work body who work in a direct clinical practice role with people who use psychoactive substances, to participate in a research study exploring harm reduction.

The purpose of this research study is to explore harm reduction as direct clinical practice with individuals who use psychoactive substances in rural Central Ontario. The study seeks to accomplish the following three objectives:

1. To identify how social workers' perceive harm reduction as part of their direct clinical practice in working with individuals in who use psychoactive substances in rural Central Ontario.
2. To support the OCSWSSW and other social work regulatory bodies in the development of practice principles to aid in the implementation of harm reduction as an evidence-informed practice in social work.

Participation in the study will take approximately 45 – 60 minutes. You will be asked to sign a consent form that again outlines the nature of the study and the risks involved in participating. You will also be asked to complete a demographic questionnaire, and take part in a semi-structured interview. Your participation will allow you to share your perceptions and experiences in order to support a greater understanding of harm reduction and the implementation of harm reduction for people who use substances in an effort to expand the available literature, and to better inform and support social workers in developing effective ways to implement harm reduction in their direct practice communities across Ontario, particularly in rural communities.

**Your participation in this study is completely voluntary. You may withdraw from the study at any time without penalty or consequence.**

Your name will not be linked to your responses in any way. Hard copies of the audio recording, consent forms, and demographic forms will be stored in a locked cabinet

in Thesis Supervisor's office and will be shredded or destroyed in 2024. Only the results of the analysis of the accumulated data will be used in preparing community and academic presentations and articles for peer reviewed publication. You will be provided a copy of the information letter and the consent form to keep in your own records.

If you have any questions or concerns about the research, would like an update on its status or would like a copy of the results, please contact the principal investigator, Courtney Evans, at [cx2\\_evans@laurentian.ca](mailto:cx2_evans@laurentian.ca). You may contact the Thesis Supervisor, Dr. Jan Yorke, through email at [jyorke@laurentian.ca](mailto:jyorke@laurentian.ca). Please contact the Laurentian Research Ethics Officer through the Laurentian University Research Office at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca), if you have questions about being a research participant. Thank you for your interest in this important topic and study.

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**Appendix C: Recruitment Script for Phone/Facebook/Email****Recruitment Script for Phone/Facebook/Email**

My name is Courtney Evans, and I am a Social Work student in the MSW Program through Laurentian University. I am seeking participants for a research study as part of the requirements of my MSW degree.

I am seeking social workers that are registered with the College of Social Workers and Social Service Workers or are eligible for registration with the College. The study seeks to explore social worker perceptions' in implementing harm reduction as part of their direct clinical practice in rural Central Ontario. In participating, you will be asked to reflect on your perception of harm reduction in your direct practice with individuals who use psychoactive substances, in order to support the broadening the social work literature related to harm reduction as a direct practice approach.

If you are interested in this topic and in participating, have any questions, or would like further information, please call Courtney Evans directly, at 705-349-2570, or through email at [cx2\\_evans@laurentian.ca](mailto:cx2_evans@laurentian.ca). Please contact the Laurentian Research Ethics Officer through the Laurentian University Research Office at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca), if you have questions about being a research participant in a research study.

**Appendix D: Consent Form**

Harm Reduction with People Who Use Psychoactive Substances:  
Social Workers' Perceptions in Implementing Harm Reduction in their Direct Clinical  
Practice in Rural Central Ontario

I have read the information letter for this study and understand its details. I understand that the purpose of this research is to explore harm reduction as it pertains to direct clinical practice with people who use psychoactive substances by identifying how harm reduction is perceived amongst social workers working in rural Central Ontario in their direct clinical practice.

I understand that I will complete a demographic questionnaire and participate in a 45-60 minute interview with a researcher. I understand that I will not be asked to provide my name or any other identifying information in the interview. I understand that the interviews will be audio recorded and transcribed for analysis by the researcher.

I acknowledge that I am free to withdraw my participation at any time without penalty.

I understand that hard copies of the interviews, consent forms, and demographic forms will be stored in a locked cabinet in the Thesis Supervisor's office and will be shredded or destroyed in 2024.

Any questions about the research and my participation have been answered to my satisfaction. I understand the information presented and I agree to participate.

I understand that I may contact the Thesis Supervisor, Dr. Jan Yorke, at [jyorke@laurentian.ca](mailto:jyorke@laurentian.ca) or Research Ethics Officer, Laurentian University Research Office at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca) if I have questions about being a research participant in a research study.

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Participant's signature

Date

Courtney Evans, BSW, RSW, MSW Candidate  
Laurentian University, School of Social Work, Sudbury, ON  
1-705-349-2570  
[cx2\\_evans@laurentian.ca](mailto:cx2_evans@laurentian.ca)

**Appendix E: Demographic Questionnaire**

Harm Reduction with People Who Use Psychoactive Substances:  
Social Workers' Perceptions in Implementing Harm Reduction in their Direct Clinical  
Practice in Rural Central Ontario

1. Gender Identity. I identify as (a):

\_\_\_\_\_

2. How old are you? \_\_\_\_\_ I would prefer not to answer \_\_\_\_\_

3. How would you best identify your ethnicity and/or cultural background?

\_\_\_\_\_

4. What language do you prefer to communicate in?

\_\_\_\_\_

5. What post-secondary education have you completed? (Please select all  
diploma/degrees that apply)

SSW \_\_\_\_\_ BSW \_\_\_\_\_ MSW \_\_\_\_\_ PhD \_\_\_\_\_

Other(s)(Please specify): \_\_\_\_\_

\_\_\_\_\_

6. Are you currently registered with the Ontario College of Social Workers and  
Social Service Workers (OCSWSSW)? Yes \_\_\_\_\_ No \_\_\_\_\_

7. What type of agency, organization, or programming best describes your current  
employment setting? (Please pick item that best describes the setting of your  
current, primary employment position)

Community Support Services \_\_\_\_\_

Inpatient/Residential Support Services	_____
Residential Treatment Services	_____
Withdrawal Management Services	_____
Substance Use/Abuse Support Services	_____
Mental Health Support Services	_____
Crisis Intervention Services	_____
Private practice	_____
Health care setting	_____
Housing Support Services/Shelter	_____
Correctional Services/Probation/Parole	_____
Other (Please specify: _____	



**Appendix F: Research Ethics Board Approval**

**APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN  
SUBJECTS**

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New <b>X</b> / Modifications to project / Time extension	
<b>Name of Principal Investigator and school/department</b>	Courtney Evans (PI) Faculty of Health/School of Social Work; Janet Yorke (Supervisor)
<b>Title of Project</b>	Harm Reduction with People Who Use Psychoactive Substances: Social Worker Perceptions' of Implementing Harm Reduction as Direct Practice In Rural Central Ontario Communities
<b>REB file number</b>	6013787
<b>Date of original approval of project</b>	June 24, 2018
<b>Date of approval of project modifications or extension (if applicable)</b>	
<b>Final/Interim report due on:</b> <i>(You may request an extension)</i>	June 24, 2019
<b>Conditions placed on project</b>	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with

Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

A handwritten signature in black ink, appearing to read 'Susan Boyko', with a stylized flourish extending to the right.

Susan Boyko, PhD, Vice Chair, *Laurentian University Research Ethics Board*